FILED

No. (1) 96 578 OCT 7 1996

OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1996

ALLEMNORE COMMUNITY HOSPITAL, INC., et al.,

Petitioners,

v.

THE UNITED STATES,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

PETITION FOR WRIT OF CERTIORARI

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October 7, 1996

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87 pp

QUESTIONS PRESENTED

1. Whether Congress in section 205(h) of the Social Security Act, made applicable to Medicare by 42 U.S.C. § 1395ii, impliedly precluded Tucker Act jurisdiction over a Medicare provider's claims for money damages when the Medicare provider – through no fault of its own – has no available judicial remedy under the Medicare statute.

2. Whether Congress in the 1972 and 1974 amendments to the Social Security Act, which enacted a process for judicial review of Medicare Part A claims, impliedly repealed Tucker Act jurisdiction over a Medicare provider's claims for money damages when the Medicare provider – through no fault of its own – has no available judicial remedy under the Medicare statute.

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES

The following hospitals in *Allemnore Community Hospital, Inc. v. United States*, No. 95-5048 (Fed. Cir.), are parties to the proceeding:

1. ALLEMNORE COMMUNITY HOSPITAL, INC., d/b/a Humana Hospital – Tacoma;

2. AMERICAN MEDICAL (CENTRAL), INC., d/b/a Boulevard Hospital, Citizen General Hospital, Golden Plains Community Hospital, Northwest Hospital and White Settlement Hospital;

3. AMERICAN MEDICAL HOLDING, INC., d/b/a Doctors General Hospital;

4. AMI HOSPITALS OF TEXAS, LTD., d/b/a Brownsville Medical Center, Community Hospital of Tyler, Park Place Hospital, Park Plaza Hospital, Southwestern General Hospital, and Twelve Oaks Hospital;

5. AMISUB OF CALIFORNIA, d/b/a Tarzana Regional Medical Center;

6. AMISUB (CULVER UNION HOSPITAL), INC., d/b/a Culver Union Hospital;

7. BEAUMONT HOSPITAL, INC., d/b/a Beaumont Medical Surgical Hospital;

8. COMMUNITY HOSPITALS OF HUMANA, INC., d/b/a Humana Hospital – Cypress;

9. COMMUNITY HOSPITAL OF THE PALM BEACHES, INC., d/b/a Humana Hospital – Palm Beaches;

10. DALLAS FAMILY HOSPITAL, INC., d/b/a Dallas Family Hospital;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

11. DOCTORS HOSPITAL OF AUGUSTA, INC., d/b/a Humana Hospital – Augusta;

12. DOCTORS HOSPITAL OF HOLLYWOOD, INC., d/b/a Doctors Hospital of Hollywood;

13. GENERAL HOSPITALS OF HUMANA, INC., d/b/a Humana Hospital – Cartersville, Humana Hospital – Davis North, Humana Hospital – Newman;

14. GWINNETT COMMUNITY HOSPITAL, INC., d/b/a Humana Hospital – Gwinnett;

15. HUMANA HOSPITAL CORPORATION, INC., d/b/a Humana Hospital – Corpus Christi, Humana Women's and Children's Hospital, Humana Women's Hospital – Indianapolis;

16. HUMANA HOSPITAL CORPORATION, INC., d/b/a Humana Hospital Southmore;

17. HUMANA, INC., d/b/a Humana Hospital – Biscayne, Humana Hospital – Lexington, Humana Hospital – Mountain View;

18. HUMANA, INC., d/b/a Humana Hospital – Sharpstown;

19. HUMANA MEDICAL CORPORATION, d/b/a Humana Hospital – Enterprise, Humana Hospital – Shoals, Humana Hospital – Russelville;

20. HUMANA OF ALASKA, INC., d/b/a Humana Hospital;

21. HUMANA OF ARIZONA, INC., d/b/a Humana Hospital – Phoenix, Humana Hospital – Desert Valley;

22. HUMANA OF AURORA, INC., d/b/a Humana Hospital – Aurora;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

23. HUMANA OF FLORIDA, INC., d/b/a Humana Hospital – St. Petersburg, Humana Women's Hospital – Tampa, Humana Hospital – Kissimmee, Humana Hospital – Lucerne, Humana Hospital – Bennett, Humana Hospital – Daytona Beach, Humana Hospital – Fort Walton Beach, Humana Hospital – Orange Park;

24. HUMANA OF ILLINOIS, INC., d/b/a Humana Hospital – Springfield;

25. HUMANA OF KANSAS, INC., d/b/a Humana Hospital – Dodge City, Humana Hospital – Overland Park;

26. HUMANA OF KENTUCKY, INC., d/b/a Humana Hospital – Audubon, Humana Hospital – Lake Cumberland, Humana Hospital – Louisa, Humana Hospital – Suburban;

27. HUMANA OF LOUISIANA, INC., d/b/a Humana Hospital – Oakdale, Humana Hospital – Springhill, Humana Hospital – Ville Platte;

28. WHG, INC., d/b/a Humana Hospital – Winn Parish;

29. HUMANA OF TENNESSEE, INC., d/b/a Humana Hospital – Morristown, Humana Hospital – McFarland;

30. HUMANA OF TEXAS, INC., d/b/a Humana Hospital – Brazos Valley;

31. HUMANA OF VIRGINIA, INC., d/b/a Humana Hospital – Bayside;

32. HUMANA OF WEST VIRGINIA, INC., d/b/a Humana Hospital – Greenbrier Valley, Humana Hospital – St. Lukes/Bluefield;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

33. HUMANA VIRGINIA HOSPITAL CORPORATION, d/b/a Humana Hospital – St. Lukes Richmond;

34. HUMEDICENTERS, INC., d/b/a Humana Hospital – East Montgomery, Humana Hospital – New Orleans;

35. HUMHOSCO, INC., d/b/a Humana Hospital – Brandon, Humana Hospital – Northside;

36. HUNTINGTON INTERCOMMUNITY HOSPITAL, INC., d/b/a Humana Hospital – Huntington Beach;

37. LIFEMARK HOSPITALS OF FLORIDA, INC., d/b/a Palmetto General Hospital;

38. LIFEMARK HOSPITALS OF MISSOURI, INC., d/b/a Columbia Regional Hospital;

39. LIFEMARK HOSPITALS OF TEXAS, INC., d/b/a Eastway General Hospital;

40. LUCY LEE HOSPITAL, INC., d/b/a Lucy Lee Hospital;

41. MCALLEN MEDICAL CENTER, INC., d/b/a McAllen Medical Center;

42. MEDICAL HORIZONS, LTD., a partnership wherein AMERICAN MEDICAL (CENTRAL), INC. and LIFEMARK HOSPITALS OF TEXAS, INC. are partners, d/b/a Nacogdoches Medical Center;

43. MGH MEDICAL, INC., d/b/a Humana Hospital – Metropolitan;

44. OAKCLIFF MEDICAL AND SURGICAL HOSPITAL, INC., d/b/a Southwest Dallas Hospital (Oakcliff Medical & Surgical Hospital;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

45. ODESSA HOSPITAL, LTD., wherein AMERICAN MEDICAL (CENTRAL), INC. is the general partner, d/b/a Odessa Womens & Childrens Hospital;

46. PALM BEACH COMMUNITY HOSPITAL, INC., d/b/a Palm Beach Gardens Medical Center;

47. PANORAMA COMMUNITY HOSPITAL, INC., d/b/a Panorama Community Hospital;

48. SAN DIMAS COMMUNITY HOSPITAL, INC., d/b/a San Dimas Community Hospital;

49. SHALMET GENERAL HOSPITAL, INC. and UHS OF DE LA RONDE, INC., d/b/a Shalmet Medical Centers;

50. SOUTHWEST JEFFERSON COMMUNITY HOSPITAL, INC., d/b/a Humana Hospital – Southwest;

51. SUBURBAN MEDICAL CENTER AT HOFFMAN ESTATES, INC., d/b/a Humana Hospital – Hoffman Estates;

52. UHS OF AUBURN, INC., d/b/a Auburn General Hospital;

53. UHS OF BELLMONT, INC., d/b/a Belmont Community Hospital;

54. UHS OF BETHESDA, INC., d/b/a Mt. Sinai Hospital North (Bethesda Hospital);

55. UHS OF CENTRALIA, INC., d/b/a Centralia General Hospital;

56. UHS OF DE LA RONDE, INC., d/b/a De La Ronde Hospital;

57. UHS OF RIVER PARISHES, INC. d/b/a River Parishes Medical Center;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

58. UHS OF RIVERTON, INC., d/b/a Riverton Hospital;

59. UHS OF SHREVEPORT, INC., d/b/a Doctors Hospital of Shreveport;

60. UNIVERSAL HEALTH SERVICES OF INLAND VALLEY, INC., d/b/a Inland Valley Regional Medical Centers;

61. UNIVERSAL HEALTH SERVICES OF NEVADA, INC., d/b/a Valley Hospital Medical Center;

62. VICTORIA REGIONAL MEDICAL CENTER, INC., d/b/a Victoria Regional Medical Center;

63. WEST ANAHEIM COMMUNITY HOSPITAL, INC., d/b/a Humana Hospital – West Anaheim;

64. WEST HILLS HOSPITAL, INC., d/b/a Humana Hospital – West Hills;

65. WESTLAKE MEDICAL CENTER, INC. d/b/a Westlake Medical Center;

66. WESTMINSTER COMMUNITY HOSPITAL, INC., d/b/a Humana Hospital – Westminster;

67. BEAUMONT HOSPITAL, INC. d/b/a Beaumont Medical Surgical Hospital;

68. COMMUNITY HOSPITAL OF THE PALM BEACHES, INC. d/b/a Humana Hospital – Palm Beach;

69. HUMANA, INC. – d/b/a Humana Hospital – San Leandro, Humana Hospital – Sebastian, Humana Hospital – Sunrise;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

70. HUMANA HOSPITAL CORPORATION, INC. – d/b/a Humana Hospital – Clear Lake, Humana Hospital – San Antonio, Humana Hospital – Corpus Christi, Humana Women's and Children's Hospital, Humana Hospital – Southmore,

71. HUMANA MEDICAL CENTERS, INC. – d/b/a Humana Specialty Hospital Memphis;

72. HUMANA MEDICAL CORPORATION – d/b/a Humana Hospital – Huntsville, Humana Hospital – Florence, Humana Hospital – Enterprise, Humana Hospital – Shoals, Humana Hospital – Russelville;

73. HUMANA OF ARIZONA, INC. d/b/a Humana Hospital – Desert Valley;

74. HUMANA OF FLORIDA, INC. – d/b/a Humana Hospital – Pasco, Humana Women's Hospital – Tampa, Humana Hospital – Ft. Walton Beach;

75. HUMANA OF LOUISIANA, INC. d/b/a Humana Hospital – Springhill; Humana Hospital – Oakdale;

76. HUMANA OF NORTH CAROLINA, INC. – d/b/a Humana Hospital – Greensboro;

77. HUMANA OF TENNESSEE, INC. d/b/a Humana Hospital – Eastridge, Humana Hospital – Morristown, Humana Hospital – McFarland;

78. HUMANA OF TEXAS, INC. – d/b/a Humana Hospital – Abilene, Humana Hospital – Baytown, Humana Hospital – Brazos Valley;

79. HUMANA OF VIRGINIA, INC. – d/b/a Humana Hospital – University of Louisville, Humana Hospital – Bayside;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

80. HUMANA OF WEST VIRGINIA, INC. d/b/a Humana Hospital – Greenbrier Valley; Humana Hospital – St. Luke's/Bluefield;

81. HUMEDICENTERS, INC. – d/b/a Humana Hospital – Clinch Valley, Humana Hospital – East Montgomery;

82. HUMHOSCO, INC. d/b/a/ Humana Hospital – Brandon;

83. HUNTINGTON INTERCOMMUNITY HOSPITAL, d/b/a Humana Hospital – Huntington Beach;

84. WEST ANAHEIM COMMUNITY HOSPITAL d/b/a Humana Hospital – West Anaheim;

85. WESTMINSTER COMMUNITY HOSPITAL d/b/a Humana Hospital – Westminster;

86. WGH, INC. d/b/a Humana Hospital – Winn Parish

The parent companies of the above-referenced parties include:

Columbia/HCA Healthcare Company,

Tenet Healthcare Corporation, or

Universal Health Services, Inc.

There are no other parent companies or non-wholly owned subsidiaries.

The following hospitals in *Alice Physicians & Surgeons Hospital, Inc. v. United States*, No. 95-9057 (Fed. Cir.) are parties to the proceeding:

1. ALICE PHYSICIANS & SURGEONS HOSPITAL, INC.;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

2. ALVIN COMMUNITY HOSPITAL, INC.;
3. AMISUB OF GEORGIA, INC. d/b/a/ Barrow Medical Center;
4. CLAREMORE REGIONAL HOSPITAL, INC.;
5. CLEARWATER COMMUNITY HOSPITAL, INC.;
6. COASTAL BEND HOSPITAL, INC.;
7. DANFORTH HOSPITAL, INC.;
8. DENTON REGIONAL MEDICAL CENTER, INC.;
9. DOCTORS HOSPITAL OF LOREDO, INC.;
10. DOCTORS' HOSPITAL OF OPELOUSAS, LTD.;
11. DOCTORS' MEMORIAL HOSPITAL – SPARTANBURG, LTD;
12. FORT BEND HOSPITAL, INC.;
13. GARDEN PARK COMMUNITY HOSPITAL, LTD.;
14. KATY MEDICAL CENTER, INC.;
15. MEDICAL ARTS HOSPITAL OF DALLAS, INC.;
16. MEDICAL ARTS HOSPITAL OF TEXARKANA, INC.;
17. MEDICAL PLAZA HOSPITAL, INC.;
18. NORTH TEXAS MEDICAL CENTER, INC.;
19. NOTAMI HOSPITALS OF CALIFORNIA, INC., d/b/a Mission Bay Memorial Hospital; Visalia Community Hospital;
20. NOTAMI HOSPITALS OF LOUISIANA, INC. d/b/a Westpark Community Hospital;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

21. NOTAMI HOSPITALS OF MISSOURI, INC. d/b/a Springfield Community Hospital;
22. PARKWAY HOSPITAL, INC.;
23. RIVERSIDE HOSPITAL, INC.;
24. ROUND ROCK HOSPITAL, INC.;
25. SOUTHWESTERN MEDICAL CENTER, INC.;
26. TERRELL COMMUNITY HOSPITAL, INC.;
27. WEST LOS ANGELES PHYSICIANS HOSPITAL, LTD.

The parent companies of the listed parties are:

Columbia/HCA Healthcare Company, or

Tenet Healthcare Corporation. There are no other parent companies or non-wholly owned subsidiaries.

The following hospitals in *Aiken Community Hospital, Inc., v. United States*, No. 95-5108 (Fed. Cir.) are parties to the proceeding:

1. AIKEN COMMUNITY HOSPITAL, INC. d/b/a Aiken Regional Medical Center;
2. CASTLEVIEW HOSPITAL, INC. d/b/a Castleview Hospital;
3. CENTRAL FLORIDA REGIONAL HOSPITAL, INC. d/b/a Central Florida Regional Hospital;
4. CHESTERFIELD GENERAL HOSPITAL, INC. d/b/a Chesterfield General Hospital;
5. COMMUNITY HOSPITAL, INC. d/b/a Community Hospital of Mayfield;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

6. CORONADO COMMUNITY HOSPITAL, INC. d/b/a Coronado Hospital;
7. CRESTWOOD HOSPITAL AND NURSING HOME, INC. d/b/a Crestwood Hospital;
8. DAUTERIVE HOSPITAL CORPORATION d/b/a Dauterive Hospital;
9. DOCTORS HOSPITAL OF MOBILE, INC. d/b/a Knollwood Park Medical Center and Doctors Hospital of Mobile;
10. EAST POINTE HOSPITAL, INC. d/b/a East Pointe Hospital;
11. EDMOND MEMORIAL HOSPITAL, INC. d/b/a Edmond Memorial Hospital;
12. FORT WORTH MEDICAL PLAZA, INC. d/b/a Medical Plaza Hospital;
13. GALEN HOSPITAL CORPORATION, INC. d/b/a Village Oaks Medical Center,
14. GENERAL CARE CORP. d/b/a/ Woodland Community Hospital and Regional Hospital of Jackson;
15. GENERAL HEALTH SERVICES, INC. d/b/a Edward H. White Hospital;
16. GREENVIEW HOSPITAL, INC. d/b/a Greenview Hospital;
17. HAMILTON MEDICAL CENTER, INC. d/b/a Hamilton Medical Center;
18. HARTSELLE MEDICAL CENTER, INC. d/b/a Hartselle Medical Center;
19. HCA HEALTH SERVICES OF ALABAMA, INC. d/b/a Parkway Medical Center Hospital;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

20. HCA HEALTH SERVICES OF FLORIDA, INC. d/b/a Medical Center of Port St. Lucie, North Florida Regional Medical Center, Northwest Regional Hospital, Bayonet Point/Hudson Medical Center and Oak Hill Hospital;

21. HCA HEALTH SERVICES OF LOUISIANA, INC. d/b/a North Monroe Hospital;

22. HCA HEALTH SERVICES OF MIDWEST, INC. d/b/a Doctors Hospital of Little Rock;

23. HCA HEALTH SERVICES OF NEW HAMPSHIRE, INC. d/b/a Parkland Medical Center and Portsmouth Regional Hospital;

24. HCA HEALTH SERVICES OF OKLAHOMA, INC. d/b/a Presbyterian Hospital and St. Mary's Hospital;

25. HCA HEALTH SERVICES OF TENNESSEE, INC. d/b/a Smyrna Medical Center;

26. HCA HEALTH SERVICES OF TEXAS, INC. d/b/a South Austin Medical Center, Grant-Buie Hospital, West Houston Medical Center and Medical Center Hospital;

27. HCA HEALTH SERVICES OF VIRGINIA, INC. d/b/a Henrico Doctors Hospital;

28. HCA HIGHLAND HOSPITAL, INC. d/b/a Highland Hospital;

29. HCA SOUTH CAROLINA, INC. d/b/a Marlboro Park Hospital;

30. HOSPITAL CORPORATION OF KENTUCKY d/b/a Valley View Medical Center;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

31. HOSPITAL DEVELOPMENT & SERVICE CORP. d/b/a Plantation General Hospital;

32. HSP OF TEXAS, INC. d/b/a Medical Center of Plano;

33. LAKESIDE HOSPITAL, INC. d/b/a Lakeside Hospital;

34. LAWNWOOD MEDICAL CENTER, INC. d/b/a Lawnwood Regional Medical Center;

35. MARION COMMUNITY HOSPITAL, INC. d/b/a Marion Community Hospital;

36. MEDICAL CENTER OF SANTA ROSA, INC. d/b/a Santa Rosa Medical Center;

37. MOUNTAIN VIEW HOSPITAL, INC. d/b/a Mountain View Hospital;

38. MYRTLE BEACH HOSPITAL, INC. d/b/a Grand Strand General Hospital;

39. NAVARRO MEMORIAL HOSPITAL, INC. d/b/a Navarro Regional Hospital;

40. NORTH BEACH HOSPITAL, INC. d/b/a North Beach Hospital;

41. NORTH TRIDENT REGIONAL HOSPITAL, INC. d/b/a Trident Regional Medical Center;

42. OKALOOSA HOSPITAL, INC. d/b/a Twin Cities Hospital;

43. PASADENA BAY SHORE HOSPITAL, INC. d/b/a Pasadena Bayshore Medical Center;

44. S.P. ACQUISITION CORP. d/b/a South Pittsburgh Municipal Hospital;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

45. SELMA MEDICAL CENTER HOSPITAL, INC. d/b/a Selma Medical Center;

46. SUN CITY HOSPITAL, INC. d/b/a Sun City Hospital;

47. SUNBELT REGIONAL MEDICAL CENTER, INC. d/b/a Sunbelt Regional Medical Center West;

48. TAMARAC HOSPITAL CORPORATION, INC. d/b/a University Hospital.

49. THE L.V. STABLER MEMORIAL HOSPITAL OF GREENVILLE, INC. d/b/a L.V. Stabler Memorial Hospital;

50. TRINITY HOSPITAL CORPORATION d/b/a Trinity Hospital;

51. VISTA HILLS MEDICAL CENTER, INC. d/b/a Vista Hills Medical Center;

52. WEST VALLEY MEDICAL CENTER, INC. d/b/a West Valley Medical Center;

53. WHARTON HOSPITAL CORPORATION, d/b/a Gulf Coast Medical Center;

54. WOMEN'S AND CHILDREN'S HOSPITAL, INC. d/b/a Women's and Children's Hospital;

55. WYOMING HEALTH SERVICES, INC. d/b/a Riverton Memorial Hospital;

56. WYSONG MEDICAL CENTER, INC. d/b/a Wysong Medical Center;

Columbia/HCA Healthcare Company is the parent company of these hospitals. There are no non-wholly owned subsidiaries.

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

The following hospitals in *Accord Medical Management Ltd., et al. v. United States of America,* No. 95-5054 (Fed. Cir.) are parties to the proceeding:

1. Accord Medical Management, Limited, d/b/a Nix Medical Center;
2. Akron General Medical Center;
3. Baptist Memorial Hospital System;
4. Bexar County Hospital District;
5. Bryan Memorial Hospital;
6. Citizens Medical Center;
7. Dakota Hospital;
8. East Texas Medical Center;
9. Episcopal Hospital;
10. Hendrick Medical Center;
11. Herrin Hospital;
12. High Plains Baptist Hospital;
13. Holmes Regional Medical Center, Inc.;
14. Immanuel Medical Center, Inc.;
15. Incarnate Word Hospital;
16. Marshall Memorial Hospital;
17. Medical Center Hospital;
18. Medical College of Ohio Hospitals;
19. Medical College of Virginia Hospitals/Virginia Commonwealth University;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

20. Memorial Hospital of Carbondale;
21. Mercy Medical Center;
22. Metropolitan Hospital, L.P.;
23. Northeast Medical Center Hospital;
24. Presbyterian Hospital of Dallas;
25. Saint Joseph Hospital;
26. Santa Rosa Health Care Corporation;
27. Scott & White Memorial Hospital;
28. Shannon West Texas Memorial Hospital;
29. Sid Peterson Memorial Hospital;
30. Southwest Texas Methodist Hospital;
31. Spohn Hospital;
32. Spohn-Kleberg Hospital;
33. St. Anthony's Hospital;
34. St. David's Hospital;
35. St. John's Hospital & Health Center;
36. St. Joseph's Hospital & Health Center;
37. St. Mary's Hospital of Richmond;
38. Tarrant County Hospital District;
39. Taylor Hospital;
40. Texoma Medical Center, Inc.;
41. Titus County Memorial Hospital;

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

42. Tuality Community Hospital;
43. University of Virginia Medical Center;
44. Valley Baptist Medical Center;
45. Wichita General Hospital;
46. Wilson N. Jones Memorial Hospital;
47. Winchester Medical Center, Inc.
48. Harris Methodist Health Services

The parent companies of the above-referenced parties include:

Columbia/HCA Healthcare Corporation is the parent company of Southwest Texas Methodist Hospital. There are no other parent companies or non-wholly owned subsidiaries.

The following hospitals in *Allegheny General Hospital v. United States*, No. 95-5099 (Fed. Cir.), are parties to the proceeding:

1. Allegheny General Hospital,
2. Baptist Medical Center of Oklahoma,
3. Baptist Memorial Hospital,
4. Baptist Memorial Hospital-Blytheville,
5. Baptist Memorial Hospital-Booneville,
6. Baptist Memorial Hospital-Desoto,
7. Baptist Memorial Hospital-Eastern Ozarks,
8. Baptist Memorial Hospital-Forrest City,

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

9. Baptist Memorial Hospital-Germantown,
10. Baptist Memorial Hospital-Huntingdon,
11. Baptist Memorial Hospital-Lauderdale,
12. Baptist Memorial Hospital-North Mississippi,
13. Baptist Memorial Hospital-Osceola,
14. Baptist Memorial Hospital-Tipton,
15. Baptist Memorial Hospital-Union City,
16. Baptist Memorial Hospital-Union County,
17. Bass Memorial Baptist Hospital,
18. Beverly Hills Medical Center,
19. Borgess Medical Center,
20. Cape Coral Medical Center, Inc.,
21. Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center,
22. Coastal Communities Hospital,
23. Condell Medical Center,
24. Coral Gables Hospital,
25. Deaconess Hospital,
26. Decatur Hospital,
27. Doctor's Hospital of Staten Island, Inc.,
28. Durham County Hospital Corporation d/b/a Durham Regional Hospital,
29. Farmers Union Hospital Association d/b/a Community Hospital,

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

30. Garland Community Hospital,
31. Harbor View Medical Center,
32. Health One Mercy Hospital,
33. Health One Unity Hospital,
34. Helen Ellis Memorial Hospital,
35. Hillcrest Medical Center,
36. Houston Northwest Medical Center,
37. Iowa Methodist Medical Center,
38. Kingsbrook Jewish Medical Center,
39. Lake Pointe Medical Center,
40. Laughlin Memorial Hospital, Inc.,
41. Lewisburg Community Hospital,
42. Maury Regional Hospital,
43. Memorial General Hospital District,
44. Memorial Hospital of Gardena,
45. Memorial Hospital of San Leandro,
46. Memorial Hospital of Southern Oklahoma,
47. Meridia Euclid Hospital,
48. Meridia Hillcrest Hospital,
49. Meridia Huron Hospital,
50. Meridia Suburban Hospital,
51. Meridian Regional Hospital,

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

52. Mesquite Physicians Hospital,
53. Methodist Hospitals of Memphis, Inc.,
54. Metropolitan Medical Center,
55. Metropolitan-Mount Sinai Medical Center,
56. Middle Tennessee Medical Center, Inc.,
57. Muskogee Medical Center Authority d/b/a Muskogee Regional Medical Center,
58. Nashville Memorial Hospital,
59. Norman Regional Hospital,
60. North Miami Medical Center,
61. Owensboro-Daviess County Hospital,
62. Physicians Hospital,
63. Providence Hospital of Mobile,
64. Providence Memorial Hospital,
65. Queen of the Valley Hospital of Napa, California,
66. Redwood Memorial Hospital of Fortuna,
67. Rio Hondo Hospital,
68. Ross General Hospital,
69. St. Anthony Hospital,
70. Saint Elizabeth Medical Center,
71. St. Francis Hospital, Inc.,
72. Saint Francis Hospital, Inc.,
73. Saint John Medical Center, Inc.,

PARTIES TO THE PROCEEDING AND THEIR PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES – Continued

74. St. Joseph Hospital of Eureka,

75. St. Joseph Hospital of Orange,

76. St. Jude Hospital d/b/a St. Jude Medical Center,

77. St. Mary's Medical Center, Inc.,

78. St. Thomas Hospital,

79. Santa Rosa Memorial Hospital,

80. Sisters of Saint Joseph of Texas d/b/a St. Mary of the Plains Hospital and Rehabilitation Center,

81. Tippah County Hospital,

82. Tulsa Regional Medical Center,

83. United Hospital, Inc.,

84. University Medical Center,

85. Valley View Regional Hospital,

86. Venice Hospital,

87. Washoe Medical Center, and

88. Winona Memorial Hospital.

OrNda Health Corp. is the parent company of seventeen of the hospitals. There are no other parent companies or non-wholly owned subsidiaries.

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PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Petitioners Allemnore Community Hospital, Inc., *et al.*, Alice Physicians and Surgeons Hospital, Inc., *et al.*, Aiken Community Hospital, Inc., *et al.*, Accord Medical Management Ltd., *et al.*, and Allegheny General Hospital, *et al.* (Hospitals) petition for writ of certiorari to review the judgment of the United States Court of Appeals for the Federal Circuit in this case.

OPINIONS AND ORDERS BELOW

The Order of the United States Court of Appeals for the Federal Circuit, App. 1-2, and the Orders of the United States Court of Federal Claims, in *Aiken Community Hospital, Inc., et al.*, App. 3-4, and *Alice Physicians and Surgeons Hospital, Inc., et al.*, App. 11-12, are unpublished. The opinion of the United States Court of Federal Claims in *Allemnore Community Hospital, Inc., et al.* is reported at 32 Fed. Cl. 608 (1995), App. 5-10.

JURISDICTION

This is an appeal from a judgment of the Federal Circuit entered July 9, 1996, and over which Congress, in 28 U.S.C. § 1254(1), has granted the Court jurisdiction by writ of certiorari.

STATUTES

The following statutes are involved in these cases and are set out verbatim in the Appendix: 28 U.S.C. § 1491(a)(1) and 42 U.S.C. §§ 405(h), 1395ii, 1395oo(a), and 1395oo(f)(1).

STATEMENT OF THE CASE

I. LEGAL BACKGROUND

The underlying substantive issue in this action concerns payments to hospitals participating in Medicare, a federal program that provides health insurance for the aged and disabled, *see generally* 42 U.S.C. § 1395c (describing the Medicare program). Under Medicare, eligible individuals are entitled to have the Secretary of Health and Human Services (HHS) pay for statutorily specified health services, e.g., inpatient hospital services, that they receive. *Id.* § 1395d(a)(1).

In 1983, Congress created a prospective payment system (PPS), applicable to most hospitals, including Petitioners (Hospitals), for inpatient hospital services. Under PPS, Medicare pays hospitals using a standard, prospectively determined, national rate per discharge, adjusted for the complexity of the diagnosis related group (DRG) discharge in question. 42 U.S.C. 1395ww(d)(1)(A)(ii).

Concerned that a hospital might receive inadequate DRG payments for cases consuming an extraordinarily large amount of resources in relation to other cases in the same DRG, Congress required, as part of PPS, that the Secretary provide additional payments for these cases, termed "outliers." *Id.* § 1395ww(d)(5)(A)(i)-(ii). In addition, Congress mandated:

> The total amount of the [outlier] payments . . . for discharges in a [federal] fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. § 1395ww(d)(5)(A)(iv).

Payment for inpatient services is made in two ways during a fiscal year: a hospital receives both DRG payments and estimates of outlier (and other kinds of) payments. 42 C.F.R. §§ 412.112-.118. At the end of its fiscal year, each Hospital must file a cost report with a fiscal intermediary, the Secretary's agent,[1] which determines whether the interim payments were consistent with total allowable Medicare payment. 42 U.S.C. § 1395f(a); 42 C.F.R. §§ 413.20(a), (b) and -.24(f). The intermediary audits the hospital's cost report, issues a notice of program reimbursement (NPR) specific to that hospital (delineating the amount of Medicare payment to which it is entitled), and collects any overpayment or pays any amount due the hospital. *See* 42 C.F.R. §§ 405.1803(c) and 413.60.

Through this annual settlement process, a hospital becomes aware of the amount of its own Medicare outlier payments and whether the intermediary included all appropriate discharges and correctly performed the calculation. Neither this individual hospital settlement process, nor its individual NPR, however, tells a hospital the "total amount of the [outlier] payments . . . for discharges in a fiscal year," *see* 42 U.S.C. § 1395ww(d)(5)(A)(iv), that the Secretary paid to all hospitals.[2]

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[1] The intermediaries are generally private insurance carriers, such as Blue Cross and Blue Shield, who are under contract to the Secretary and who audit provider costs and make Medicare payments to providers. *See* 42 U.S.C. § 1395h; 42 C.F.R. § 412.116.

[2] To fund the outlier payments, 42 U.S.C. §§ 1395ww(d)(2)(E) and (d)(3)(B) contain corresponding provisions requiring the Secretary to reduce the average DRG payment by a proportion equal to the proportion used to determine actual aggregate outlier payments, e.g., 5%-6% (thereby creating a pool of funds).

Ordinarily a hospital may dispute the amounts of its Medicare payments (over $10,000) through the administrative and judicial review provisions of the Medicare statute. *See* 42 U.S.C. § 1395oo(a), (f). A hospital, cannot, however, obtain judicial review under section 1395oo(f)(1) without first obtaining a final decision of the Provider Reimbursement Review Board, an administrative body within HHS. Nor can it initiate an appeal to the Board without obtaining from the Secretary or her fiscal intermediary a "final determination", *see id.* § 1395oo(a), which is traditionally furnished by the provider's NPR. A hospital must initiate the appeal process by filing a request for a hearing with the Board within 180 days of receipt of its NPR. *See id.* § 1395oo(a)(3).

A hospital, such as each of the Hospitals, which does not receive notice of the amount of aggregate outlier payments through its NPR has no opportunity to use the review procedure set up by 42 U.S.C. § 1395oo to challenge the amount of outlier payments it received. JA 120. No "final determination" is provided to an individual hospital of national outlier payment levels. *Id.*

If a provider does have a valid appeal pending at the Board on another issue, however, it may add the outlier – or any – issue to that appeal at any time before the Board hearing, even years after the appeal was docketed. 42 C.F.R. § 405.1841(a)(1).

II. FACTUAL BACKGROUND

Each Hospital entered into a written agreement with the Secretary to provide hospital services to eligible individuals pursuant to 42 U.S.C. § 1395cc. JA 118.[3] Each

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[3] The Hospitals all filed substantively identical amended complaints in the courts below. In the interest of economy, only

Hospital elected to receive Medicare payments through its intermediary pursuant to 42 U.S.C. § 1395h for the fiscal and cost reporting years in question, 1985 and 1986. *Id.* at 119.

In 1992, almost nine years after the inception of PPS, the Secretary for the first time published a schedule purporting to reflect both actual outlier payments (as a percentage of total payments) and the Secretary's target outlier percentages (of total PPS payments) for federal fiscal years (FFYs) 1984-1987. 57 Fed. Reg. 23,644 (June 4, 1992). The schedule shows actual outlier payment percentages below the targets for FFYs 1984-1987. As the Hospitals later learned, not even the 1992 Federal Register statement was accurate.

The Hospitals contend that they received outlier payments for the FFYs 1985 and 1986 cost reporting periods that were less than the outlier payments due them under 42 U.S.C. § 1395ww(d)(5)(A)(iv). The Hospitals in their Complaints have alleged that the Secretary violated a federal statute, breached the Secretary's contract with the Hospitals, implemented a regulation that is arbitrary and capricious, and violated the Hospitals' Fifth Amendment right to due process, by failing to make the required level of outlier payments. JA 120-124.

The Hospitals presented their claims to the Secretary by requesting their intermediaries to reopen and revise their determinations during the PPS cost reporting periods in question to increase the Hospitals' payments for outlier cases. Those requests were denied. JA 119-20. Because the June 4, 1992, Federal Register schedule, and the Hospitals' subsequent requests to reopen, occurred

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one such complaint, the Third Amended Complaint in *Allemnore Community Hospital v. United States*, No. 92-600C, is reproduced at Joint Appendix (JA) 109 filed with the Federal Circuit.

long after the 180-day statutory time for appeal, the Hospitals never could have availed themselves of Medicare's statutory remedies. *See* 42 U.S.C. § 1395oo(a); JA 120.

Since the Hospitals' claims were dismissed without any findings of fact, the Court must accept as true the factual allegations of Hospitals' Complaints that (1) the NPRs failed to provide the Hospitals information about the national level of outlier payments (undisputed), (2) the Secretary failed to timely notify the Hospitals of the national level of outlier payments (disputed, but no findings to the contrary), and (3) the Secretary specifically prohibited her fiscal intermediaries from granting the Hospitals' reopening requests once the Hospitals suspected the underpayments (undisputed). *See* JA 120; *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974).

III. PROCEDURAL BACKGROUND

On September 1 and 2, 1992, January 12, 1993, November 18, 1993 and July 15, 1994, the Hospitals filed suit in the Court of Federal Claims, asserting that the court had Tucker Act jurisdiction to render judgment upon a provider's claim for money damages against the United States when the Medicare statute's judicial review provisions – through no fault of the provider – were unavailable. That court previously had found jurisdiction over the claims of hospitals which under similar circumstances had no judicial review under the Medicare statute. *See, e.g., Mt. Sinai Medical Ctr. of Greater Miami, Inc. v. United States*, 13 Cl. Ct. 561 (1987), 23 Cl. Ct. 691 (1991). With the exception of *Aiken* and *Alice*, all the cases were consolidated before Judge Smith, (who also heard *Alice*).

While Hospitals' cases were pending in the Court of Federal Claims, the Federal Circuit decided *St. Vincent's Medical Ctr. v. United States*, 38 F.3d 548 (Fed. Cir. 1994). *St. Vincent's* explicitly distinguished and overruled *Mt.*

Sinai, id. at 550-51. The *St. Vincent's* court held that (1) the 1972 and 1974 amendments to the Social Security Act (which enacted § 1395oo and established the Board) impliedly repealed any remaining Tucker Act jurisdiction over Medicare provider disputes, (2) 42 U.S.C. § 405(h) precluded jurisdiction of Medicare claims under the Tucker Act, and (3) the Hospital in that case failed to exhaust its available administrative remedies. *See id.* at 548-51.

The Court of Federal Claims issued an Order to Show Cause why the cases should not be dismissed in light of *St. Vincent's*. The court subsequently granted the Government's motions to dismiss the Hospitals' claims for lack of subject matter jurisdiction, relying solely on *St. Vincent's*. *See Allemnore Community Hosp. v. United States*, 32 Fed. Cl. 608 (1995); *Aiken Community Hosp., v. United States*, No. 94-458 C (1995); *Alice Physicians and Surgeons Hosp., Inc., v. United States*, No. 93-705 C (1995); *see also* App. 3-12.

The *Allemnore* court initially drew "no conclusion concerning plaintiffs' exhaustion of statutory remedies under 42 U.S.C. § 1395oo," App. 7, but in an amended order held that *St. Vincent's* made it "irrelevant to jurisdiction", whether the Hospitals had a possible administrative remedy before the Board, quoting *St. Vincent's* holding that "initial application to the PRRB" is a "statutory prerequisite to judicial review which must be followed." App. 9-10 (quoting *St. Vincent's*, 32 F.3d at 552).

In one companion case, *Aiken*, Judge Wiese observed that, "[a]lthough plaintiffs offer a persuasive argument in support of their position, this court simply cannot turn its back to the clear and unequivocal holding against Tucker Act jurisdiction announced in *St. Vincent's*. . . . " App. 4.

The Hospitals appealed the dismissals to the United States Court of Appeals for the Federal Circuit, first requesting a hearing *in banc*, in light of the apparent

conflict between *St. Vincent's* and earlier Federal Circuit and Claims Court decisions. That request was denied. At oral argument before a panel, Judge Lourie opened the questioning by asking, "Hasn't this case been decided under another name?" referring to *St. Vincent's*. Apparently on the basis of *St. Vincent's*, on July 9, 1996, the Federal Circuit summarily affirmed the decisions of the Court of Federal Claims.

IV. LOWER COURT JURISDICTION

Hospitals appealed from a final decision of the Court of Federal Claims over which Congress, in 28 U.S.C. § 1295(a)(3), has granted the United States Court of Appeals for the Federal Circuit exclusive jurisdiction. Congress, in 28 U.S.C. § 1491(a)(1), has granted the United States Court of Federal Claims jurisdiction to render judgment upon a claim for money damages against the Government founded on a contract, the Constitution, or a federal statute or regulation.

REASONS FOR ALLOWING THE WRIT

I. THE FEDERAL CIRCUIT'S DECISION CONFLICTS WITH PRIOR DECISIONS OF THE SUPREME COURT

A. The Holding Below Conflicts With Supreme Court Precedent That 42 U.S.C. § 405(h) Does Not Impliedly Preclude Judicial Review Of A Claim For Money Damages By A Medicare Provider That Has No Review Available Under the Medicare Statute

The operative decision of the Federal Circuit here held that 42 U.S.C. § 405(h) impliedly bars judicial review of a claim by a Medicare provider even if the provider has no review available under the Medicare statute. The

Federal Circuit's holding directly conflicts with a prior decision of the Supreme Court.[4]

Section 1395ii of title 42 incorporates § 405(h) into the Medicare statute. The third sentence of 42 U.S.C. § 405(h) states: "No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." *See* 42 U.S.C. § 405(h). References to the Commissioner refer to the Secretary for purposes of the Medicare Act. *See* 42 U.S.C. § 1395ii.

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court held that 42 U.S.C. § 405(h) did not prevent Medicare suppliers from utilizing the grant of general federal question jurisdiction in 28 U.S.C. § 1331 to obtain judicial review of constitutional and statutory challenges to a Medicare Part B regulation. *See id.* at 678, 681.[5] The Court refused to accept that Congress had intended § 405(h) to bar judicial review of such significant questions. *See id.*

The Court so held in *Michigan Academy* despite the third sentence of § 405(h), which specifically states, as incorporated into the Medicare Act, that "[n]o action" against the Secretary "shall be brought under section

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[4] The Federal Circuit panel which made the decision for which a writ of certiorari is sought summarily affirmed the trial courts without opinion or discussion. The trial courts had in turn simply cited *St. Vincent's* and rejected the providers' claims. App. 1-12.

[5] Hospitals are "providers," reimbursed under Part A of the Medicare program, 42 U.S.C. § 1395x(u); physicians are paid under Part B, 42 U.S.C. § 1395x(r). Although *Michigan Academy* involved an appeal by physicians of a Part B regulation, its analysis of the scope of section 405(h) applies with equal force to these claims under Part A.

1331 . . . of title 28" to recover on a claim arising under the Medicare statute. *See id.* at 679.

The Court held, instead, that § 405(h) could not be read to preclude judicial review under 28 U.S.C. § 1331 of "substantial statutory and constitutional challenges to the Secretary's administration of Part B" of Medicare. *Id.* at 680. The Court looked to the legislative history of the Medicare statute and amendments, which made clear that Congress had intended to foreclose review only of Medicare's determinations of amounts to be paid under Part B – i.e., "quite minor matters." *See id.* (quoting 118 Cong. Rec. 33992 (remarks of Sen. Bennett)).

Given that history, and the incorporation (as opposed to direct application) of § 405(h) into the Medicare statute, the Court held that even the explicit mention of 28 U.S.C. § 1331 in § 405(h) did not bar all judicial review of more far-reaching issues. *See id.* at 680-81. In particular, this Court refused to read the third sentence of § 405(h) as furnishing the "clear and convincing evidence" needed to overcome the presumption that Congress intends judicial review of agency action. *See id.* at 681 (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967)).

Here, the Federal Circuit, in the summary decision below and in its operative decision, *St. Vincent's*, 32 F.3d at 548-552; App. 13-23,[6] did not even cite *Michigan Academy*. The court of appeals also failed to consider legislative history or the absence in § 405(h) of any mention of the Tucker Act, the jurisdictional grant applicable in the Court of Federal Claims.[7] *See id.* at 550-52. In addition,

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[6] The *St. Vincent's* opinion is reproduced in the Appendix at 13-23. Hospitals will cite herein to the Federal Reporter.

[7] As the court noted in *Ellis v. Blum*, 643 F.2d 75, 78 (2d Cir. 1981) (Friendly, J.), concerning § 405(h)'s application to mandamus jurisdiction under 28 U.S.C. § 1361, section "405(h)

the Federal Circuit misstated the language of § 405(h), mistakenly asserting that § 405(h) provides that no action arising under the Medicare Act "shall be brought in any forum or before any tribunal that is not specifically provided for in the Medicare Act." *Compare id.* at 550 *with* 42 U.S.C. § 405(h) (not stating any such rule).[8]

The Federal Circuit in *St. Vincent's* held that § 405(h) prohibited the Court of Federal Claims from exercising jurisdiction under the Tucker Act to hear Medicare provider claims. *Id.* at 551. That conclusion is directly contrary to *Michigan Academy*.

The Hospitals' claims here that the Secretary flatly violated a statutory directive to make outlier payments at a minimum level and did so without providing any notice or means for judicial review under the Medicare statute, except by the happenstance of an already pending appeal, 42 C.F.R. § 405.1841(a)(1), received absolutely no mention by the Federal Circuit, below. App. 2. The Federal Circuit's ruling leaves unreviewed an issue of national scope, aggregate outlier underpayments, the existence of which, on this record, the Hospitals had no means of appealing through the review procedures provided by the Medicare statute. This Court, as noted in *Michigan Academy*,

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contains its own limitation," i.e., it makes no pretense of precluding Tucker Act jurisdiction.

[8] The *St. Vincent's* court also overlooked all precedent in the Federal Circuit and its predecessor, the Court of Claims, on § 405(h). *See* 32 F.3d at 550-52. The Court of Claims had held on several occasions that § 405(h) did not bar Tucker Act review of Medicare claims when providers had no other avenue of judicial review and had made statutory or constitutional claims. *See, e.g., Whitecliff, Inc. v. United States*, 536 F.2d 347, 351 (Ct. Cl.), *cert. denied*, 430 U.S. 361 (1977); *Goldstein v. United States*, 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 974 (1973).

> ordinarily presumes that Congress intends the executive to obey its statutory commands and, accordingly, that it expects the courts to grant relief when an executive agency violates such a command.

See id. at 681. *Michigan Academy* requires reversal of the decision below.

B. The Federal Circuit's Decision Conflicts with Supreme Court Precedent Requiring Unambiguous Evidence of Congressional Intent to Withdraw a Tucker Act Remedy

The Federal Circuit's decision also conflicts with precedent of this Court that a Tucker Act remedy similar to that sought here is precluded only when "unambiguous" congressional intent exists to withdraw it. The operative decision below held in the alternative that Tucker Act jurisdiction had been repealed, but did not even mention those Supreme Court decisions.

This Court has stated that "a Tucker Act remedy exists unless there are unambiguous indications to the contrary." *Preseault v. Interstate Commerce Comm'n*, 494 U.S. 1, 13 (1990). In *Preseault*, the Court reaffirmed the holdings of earlier cases, including *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1019 (1984), and *Regional Rail Reorganization Act Cases*, 419 U.S. 102, 126 (1974), that a Tucker Act remedy is not impliedly repealed by enactment of another statute unless Congress has clearly withdrawn it. *See Preseault*, 494 U.S. at 12. Congress must have shown "unambiguous intention to withdraw the Tucker Act remedy" before implied repeal will be found. *See id.* (quoting *Monsanto*, 467 U.S. at 1019).

As in *Preseault*, *Monsanto*, and *Regional Rail*, the Hospitals here have alleged takings claims founded on the Constitution. JA 123. The Hospitals also have alleged other claims that fit within the grant of jurisdiction in the Tucker Act, for claims for damages against the United States founded on statute (here, 42 U.S.C. § 1395ww(d)(5)(A)(iv)), regulation (here, 42 C.F.R. §§ 412.80, -.86), and on contract (here, each Medicare provider's contract with the Secretary), *see supra* p. 5. *Cf. Preseault*, 494 U.S. at 11-12 (noting the bases for Tucker Act jurisdiction).

Neither the Federal Circuit's decision in this case nor its decision in *St. Vincent's* cited *Preseault*, *Monsanto* or *Regional Rail*. *St. Vincent's* noted only one opinion of this Court concerning implied repeal, *United States v. Fausto*, 484 U.S. 439 (1988).[9] *See* 32 F.3d at 550.

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[9] In *Fausto*, this Court held that the Civil Service Reform Act (CSRA) impliedly repealed Tucker Act jurisdiction over a claim by a low-ranking federal employee who sought damages under the Back Pay Act for money allegedly owed him after a suspension. *See* 484 U.S. at 441-43. The Court found that Congress explicitly dealt in the CSRA with the *Fausto* plaintiff's category of employment, nonpreference members of the excepted service, but specifically omitted to give those employees the right to judicial review. *Id.* at 448. The "comprehensive nature of the CSRA," the attention the statute paid "throughout" to the rights of nonpreference excepted service employees, and the omission of them in the provisions for administrative and judicial review *"combine[d]* to establish a congressional judgment" that no judicial review should be afforded for the type of personnel action involved in *Fausto*. *Id.* (emphasis added.) Even the Federal Circuit has acknowledged that *Fausto's* holding is limited, however, and refused to find repeal of Tucker Act review where the claim in question was "not covered at all by the CSRA." *Romero v. United States*, 38 F.3d 1204, 1211 (Fed. Cir. 1994).

The *St. Vincent's* panel cited *Fausto*, without any analysis, for the broad proposition that implied repeal of Tucker Act jurisdiction is found "where Congress has enacted a precisely drawn, comprehensive and detailed scheme of review in another forum. . . . " *See* 32 F.2d at 550. Yet the Medicare statute's review provision, 42 U.S.C. § 1395oo, unlike the CSRA, does not explicitly deal with circumstances like those here and then specifically omit a right to judicial review.[10]

Instead, § 1395oo makes administrative and judicial review available to Medicare providers who appeal a "final determination" (in practice the NPR) within 180 days of receipt. *See* 42 U.S.C. § 1395oo(a), (f). The NPR, however, as noted, only deals with the individual provider's payments, and does not notify a provider of aggregate national levels of reimbursement for outliers. *See, e.g.*, 42 CFR §§ 405.1803(c) and 413.60. Providers such as the Hospitals cannot begin to discern from the NPR – the trigger for the § 1395oo review procedure – whether the Secretary has violated the mandate of 42 U.S.C. § 1395ww(d)(5)(A)(iv) at issue in this case.

Section 1395oo plainly is not a comprehensive review scheme comparable to that involved in the CSRA and *Fausto*. Nor does any other provision of the Medicare statute provide a notice and review mechanism for appeals of aggregate outlier payments or any other Medicare-wide issue that is not revealed by the NPR. Finally, the Medicare statute does not include any detailed discussion of aggregate outlier payments; it simply requires

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[10] Nor could the 1972 and 1974 amendments to the Medicare statute, which enacted § 1395oo, have contemplated the unique circumstances presented in these cases, because the PPS and its outlier payment formula were not adopted by Congress until 1983.

the payment levels outlined in 42 U.S.C. § 1395ww(d)(5)(A)(iv) without further ado.

Neither *St. Vincent's* nor the one line summary decision in the case at hand discussed the review scheme of § 1395oo in any detail. The summary decision here failed to discuss anything. App. 1-2. *St. Vincent's* described § 1395oo in conclusory fashion, and quoted portions of subsections (a) and (f) which outline the review procedure based on an NPR and the possibility of expedited judicial review of a question of law or regulations. *See* 32 F.3d at 549-50.[11] *St. Vincent's* also repeated general observations made in other Federal Circuit and Court of Claims decisions that "[w]here the Medicare statute provides for review, providers must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable. . . . ", *id.* at 550 (quoting *Whitecliff*, 536 F.2d at 351). The decision did not specifically compare or apply the facts in that case to *Fausto* or any other Supreme Court precedent on implied repeal of the Tucker Act (or of any other statute). *See id.*

St. Vincent's omission to cite or discuss *Preseault*, *Monsanto*, and *Regional Rail*, among other implied repeal cases, underscores the conflict between it and applicable Supreme Court precedent. *St. Vincent's* did not even attempt to find "unambiguous indications" of congressional intent to withdraw Tucker Act jurisdiction. *See Preseault*, 494 U.S. at 13; *St. Vincent's*, 32 F.3d at 549-50. Nor did *St. Vincent's* or the panel decision in this case bother to discuss the long line of this Court's decisions

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[11] The Board has no authority to depart from a statute or regulation. *See Bethesda Hospital Ass'n. v. Bowen*, 485 U.S. 399, 406 & n.4 (1988).

that require a parallel showing of congressional intent, i.e., "clear and convincing evidence," to overcome the "strong presumption that Congress did not mean to prohibit all judicial review" of executive action. *See Abbott Labs.*, 387 U.S. at 141; *see also Reno v. Catholic Social Servs., Inc.*, 509 U.S. 43, 63-64 (1993) (same); *Michigan Academy*, 476 U.S. at 680-81 (same). Similarly, the Federal Circuit neglected to acknowledge, apply or distinguish this Court's "cardinal rule . . . that repeals by implication are not favored." *See Traynor v. Turnage*, 485 U.S. 535, 547 (1988) (quoting *Morton v. Mancari*, 417 U.S. 535, 549-50 (1974)); *St. Vincent's*, 32 F.3d at 549-50.

The Federal Circuit's reliance without comment in this case on *St. Vincent's* compounded the inadequacies of *St. Vincent's* reasoning, and offered absolutely no analysis of the dilemma in which the Hospitals found themselves. The upshot is that the Hospitals have, on this record, been left without any means to appeal the constitutional, statutory, and contractual violations by the Secretary of which they complain, and have never even received a judicial explanation of why Supreme Court precedent which favors their right to Tucker Act jurisdiction does not apply.

The truth is that the applicable precedent of this Court contradicts the holdings of the Federal Circuit below. No "unambiguous intention" to repeal Tucker Act jurisdiction has been shown here, *see Monsanto*, 467 U.S. at 1019, and the Court should grant certiorari to permit the Hospitals to be heard.

C. The Federal Circuit's Decision Conflicts with Supreme Court Precedent Requiring Conflicting Statutes to be Reconciled to the Extent Possible

The Federal Circuit's decision also conflicts with Supreme Court precedent mandating that two allegedly conflicting statutes be reconciled to the extent possible. Neither the decision at issue nor the operative *St. Vincent's* decision attempted to reconcile the Tucker Act and the Medicare statute's review provision or even cited the pertinent precedent.

Any repeal of one federal statute by another "is to be implied only if necessary to make the [more specific act] work, and even then only to the minimum extent necessary." *Silver v. New York Stock Exchange*, 373 U.S. 341, 357 (1963); *see Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 155 (1976). "[W]hen two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective." *Vimar Seguros Y Reaseguros, S.A. v. M/V Sky Reefer*, ___ U.S. ___, 115 S. Ct. 2322, 2326 (1995) (quoting *Morton*, 417 U.S. at 551 (1974)); *see Monsanto*, 467 U.S. at 1018; *Radzanower*, 426 U.S. at 155; *Regional Rail*, 419 U.S. at 133.

The two statutes involved here may be reconciled.[12] The Federal Circuit, however, has not even attempted to do so. The *St. Vincent's* decision did not cite any of the

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[12] Indeed, since 1973, the Federal Circuit and its predecessor, the Court of Claims, have routinely done so, allowing Tucker Act review of Medicare reimbursement disputes where the Medicare statute does not provide for review, *see* cases cited *supra* note 8, and *infra* p. 29. Not until *St. Vincent's* had a panel concluded that *all* Tucker Act jurisdiction over such matters was precluded. 32 F.3d at 550, 551.

above Supreme Court precedents, nor did the panel decision here. *See* 32 F.3d at 549-50; App. 1-2.

The Tucker Act and section 1395oo may be reconciled by stipulating that the latter review avenue is exclusive except when providers such as the Hospitals have never had notice of their claims in the manner contemplated by that section. In those cases, providers could bring actions under the Tucker Act or other general provisions such as 28 U.S.C. § 1331. *See Beverly Hosp. v. Bowen*, 872 F.2d 483, 486 (D.C. Cir. 1989) (parties "may invoke" federal question jurisdiction when no relief is "genuinely available" through section 1395oo).

The Federal Circuit's refusal to allow the Hospitals to pursue their unusual claims through the Court of Federal Claims' Tucker Act jurisdiction improperly fails to reconcile the two statutory review schemes.

II. THIS CASE INVOLVES IMPORTANT ISSUES OF FEDERAL LAW

A. This Court Should Exercise its Supervisory Power to Require The Federal Circuit To Apply Governing Standards of Judicial Review

The Federal Circuit below failed to ensure compliance by an administrative agency with statutory obligations. The summary decision also appears to have neglected to accept, as it was required to do, that Hospitals had no judicial review available under the Medicare statute, or to explain how such lack of review was intended by Congress.

Both *St. Vincent's* and the court below did not recognize the "strong presumption that Congress intends judicial review of administrative action." *See Michigan Academy*, 476 U.S. at 670; *see also St. Vincent's*, 32 F.3d at 549-52; App. 2. The federal courts are obligated to ensure

agency compliance with statute absent "persuasive reason to believe that" Congress intended otherwise. *Abbott Labs.*, 387 U.S. at 140; *see also Preseault*, 494 U.S. at 12-13 (no Tucker Act repeal without "unambiguous" indication of intent to do so). The Federal Circuit abdicated that responsibility in this case.

In addition, the trial court's dismissals accepted the Hospitals' factual allegations that they never received timely notice of national outlier payments and had pursued all available review, JA 120; App. 3-12, and the Federal Circuit was bound to do the same. *Scheuer*, 416 U.S. at 236.

By failing to accept those factual allegations, the Federal Circuit's decision in this case improperly departed from settled law of federal procedure. *See id.* The court of appeals did not even explain its apparent lack of adherence to the law. *See* App. 2.

B. The Federal Circuit's Jurisdictional Decision Is Contrary To The Broad Public Interest

The significance of this case goes well beyond these 298 Hospitals. The Secretary's statutory outlier payment obligation runs to all of the approximately 5,500 hospitals under PPS. In each year that the Secretary underpays for outlier cases, all hospitals receiving outlier payments suffer losses. In contrast to the "quite minor" amounts of Medicare Part B payments, over which Congress has "unambiguously" foreclosed judicial review "to avoid overloading the courts," *see United States v. Erika*, 456 U.S. 201, 208-11 (1982), this case involves hospitals with total claims of many tens of millions of dollars. Aggregate outlier underpayments nationwide are estimated by the Government's own witness at $341 million for 1985-1986. Brief for Appellants in Federal Circuit, Appendix A.

Moreover, to allow the Federal Circuit's decision to stand would be to oblige every Medicare hospital to file an appeal with the Board without knowledge of a genuine issue, simply to preserve appeal rights. Though the NPR tells a hospital nothing about whether the Secretary has satisfied her statutory outlier payment obligation, a hospital would need to file an appeal with the Board within 180 days of its NPR to have a vehicle pending through which any issue of which it later became aware could be appealed.[13]

Hospitals also would be obliged to delay prosecution of the protective appeals until whenever – perhaps years later – the Secretary finally published notice of the actual amounts of outlier payments for a particular FFY. The administrative nightmare of some 5,000 new appeals each year would overload the Secretary's administrative appeals process and severely disadvantage hospitals with pending appeals on known issues.

This jurisdictional issue also can never arise except through the Court of Federal Claims. Hospitals cannot

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[13] Were a hospital fortuitously to have appealed another issue from its NPR, the hospital could by law add the outlier issue to it. *See* 42 C.F.R. § 405.1841(a)(1). In addition, 42 CFR § 405.1841(b) allows a hospital to request (and the Board discretion to grant) for "good cause" late filing of an appeal after 180 days, but within three years of its NPR. Two courts of appeals have struck down the regulation as contrary to the statute, however. *See AlaCare Home Health Serv., Inc. v. Sullivan*, 891 F.2d 850, 855-56 (11th Cir. 1990); *St. Joseph's Hosp. v. Heckler*, 786 F.2d 848, 852-53 (8th Cir. 1986). One court of appeals has upheld the regulation. *Western Medical Enters., Inc. v. Heckler*, 783 F.2d 1376; 1379-80 (9th Cir. 1986). Moreover, the Secretary has not historically supplied outlier information within the time to allow a hospital to request a good cause exception for late filing.

allege a direct conflict with another circuit since Tucker Act jurisdictional disputes only arise through the Federal Circuit. Denying the Petition would close the door on almost twenty-five years of Tucker Act jurisdiction over Medicare provider claims where no other administrative or judicial remedy is available under the Medicare statute. *See, e.g., Whitecliff*, 536 F.2d at 349; *Goldstein*, 201 Ct. Cl. at 889-90.

C. Denying the Hospitals Judicial Review Would Violate Their Right to Equal Protection

A decision that either of sections 1395oo or 405(h) precludes judicial review of claims that could not have been brought under the appeal procedures of section 1395oo would violate the Hospitals' rights to equal protection[14] and due process[15] under the Fifth Amendment to the Constitution. *See Michigan Academy*, 476 U.S. at 680

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[14] *See Zobel v. Williams*, 457 U.S. 55, 59-60 (1982) (equal protection aspect of due process requires that the Government not distribute benefits unequally unless distinction "rationally furthers a legitimate state purpose"); *see also Belarmino v. Derwinski*, 931 F.2d 1543, 1544 (Fed.Cir. 1991).

[15] The due process clause of the Fifth Amendment requires, at a minimum, that government provide notice and some form of hearing before final deprivation of a property interest. *See Logan v. Zimmerman*, 455 U.S. 422, 433 (1982). The notice provided must be "reasonably certain to inform those affected," *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 315 (1950), and the opportunity to be heard must be given " 'at a meaningful time and in a meaningful manner.' " *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965). A property interest in a governmental benefit is created where a party has a "legitimate claim of entitlement to" the benefit. *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972); *see also Perry v. Sindermann*, 408 U.S. 593, 601-02 (1972) ("rules or mutually explicit understandings," including implied contract, may create property interest in benefit).

n.12 ("serious constitutional question" would arise by interpreting § 405(h) to deny judicial review). Such a decision would deprive Hospitals of a meaningful opportunity to challenge the Secretary's outlier payments and policy, irrationally treating them differently than hospitals that by chance had appeals pending before the Board and will have been allowed, by regulation, to add claims such as those here to those appeals.[16] In contrast, these Hospitals, who had no pending appeal, could not do so.

Indeed, the Hospitals have alleged constitutional claims on which the courts below made no findings. *See* App. 2-12; JA 1-6, 114, 122-23. "[W]here Congress intends to preclude judicial review of constitutional claims its intent to do so must be clear." *Webster v. Doe*, 486 U.S. 592, 603 (1988); *see also Woodward v. United States*, 871 F.2d 1068, 1073 (Fed. Cir. 1989), *cert. denied*, 494 U.S. 1003 (1990) (principles of *Webster* applicable to Tucker Act claims). No showing of such intent has been made here.

III. THE DECISION BELOW IS ERRONEOUS AND UNJUST

A. The Facts in this Case Significantly Differ from Those in *St. Vincent's*

The unexplained reliance of the Federal Circuit panel that decided this case on the earlier *St. Vincent's* decision from that Circuit mistakenly equated the facts in the two cases. The two factual scenarios, however, contain serious and significant differences.

In *St. Vincent's*, the hospital plaintiff had been billed in 1986 for electricity usage in earlier years. The hospital

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[16] As noted, *supra* note 13, hospitals with appeals pending at the Board may add new issues prior to hearing. 42 C.F.R. § 405.1841(a)(1).

could, and did, appeal to the Board for the year in which the costs were billed to it and two others. *See* 32 F.3d at 18; *St. Vincent's Med. Ctr. v. United States*, 29 Fed. Cl. 165, 166-67 (1993) (trial decision).

The Hospitals here, in contrast, did not receive notice of the national outlier underpayments in time to file a Board appeal for any year involved. Nor have the Hospitals *ever* received a "final determination" contemplated by § 1395oo on this matter. In fact, the Government has admitted that no such determination has been issued and appears to have no intention of ever providing one. JA 140-48. The Hospitals have no Board appeals pending for the years at issue.

Without a final determination, the Hospitals could not ever have utilized the appeal route of section 1395oo. The Federal Circuit inexcusably ignored the fact that the Hospitals' situation is entirely unlike that of the hospital plaintiff in *St. Vincent's*.

B. The Enactment of Section 1395oo in 1972 and 1974 Did Not Impliedly Repeal Tucker Act Jurisdiction Over Medicare Claims

Congress gave no sign, and certainly no sufficiently clear one, that it intended an implied repeal of Tucker Act jurisdiction over Medicare cases by its enactment of 42 U.S.C. § 1395oo in the 1972 and 1974 amendments to the Medicare statute. As noted above, the Federal Circuit in the decision below and in *St. Vincent's* ignored almost all of this Court's precedents that deal with implied repeals. Neither decision identified any "unambiguous indications" of congressional intent to repeal a Tucker Act remedy, *see Preseault*, 494 U.S. at 13, nor did either panel even discuss legislative history. *See St. Vincent's*, 32 F.3d at 549-50; App. 2.

Repeal by implication is strongly disfavored, *see, e.g., Traynor*, 485 U.S. at 547; *Radzanower*, 426 U.S. at 154, yet the two decisions below failed to acknowledge that doctrine. *See St. Vincent's*, 32 F.3d at 549-50; App. 2. "Clear and convincing evidence" of congressional intent to bar all judicial review must be shown before the presumption in favor of review may be surmounted. *See, e.g., Catholic Social Servs.*, 509 U.S. at 63-64; *Michigan Academy*, 476 U.S. at 670. Yet the Federal Circuit did not identify any such evidence. *See St. Vincent's*, 32 F.3d at 549-52; App. 2.

The Federal Circuit was required to review this case as one in which the Hospitals had no available judicial review under the Medicare statute. The trial courts dismissed the Hospitals' claims without any findings of fact, and the Hospitals' allegations that they had no notice through their NPRs, no final determination of national outlier payments, and had exhausted all available remedies, must be accepted as true. *See Scheuer*, 416 U.S. at 236. The facts, on this record, pose a stark question of whether Congress really intended to repeal all judicial review for substantial claims when the § 1395oo route is foreclosed.

The Federal Circuit flunked the test. It strained to find implied repeal, concluding without analysis in *St. Vincent's* that the Medicare statute provided a comprehensive remedy. *See* 32 F.3d at 550. The facts of this case, however, are to the contrary – and the panel here did not even deign to discuss them or attempt to reconcile the Tucker Act and § 1395oo. *See Radzanower*, 426 U.S. at 155 (requiring reconciliation of statutes to the extent possible); *Silver*, 373 U.S. at 357 (same).

St. Vincent's came closest to a discussion of congressional intent in its quotations of other lower court decisions that described § 1395oo as providing a "specific" or

"specified" route for review. *See* 32 F.3d at 550 (quoting *Appalachian Regional Healthcare, Inc. v. United States*, 999 F.2d 1573, 1577 (Fed. Cir. 1993); quoting *Whitecliff*, 536 F.2d at 351). "Specific" does not imply that a remedy is exclusive, however, *see Merriam Webster's Collegiate Dictionary* 1128 (10th ed. 1993), nor did the Federal Circuit find any evidence that Congress intended that § 1395oo be exclusive.

The 1972 and 1974 amendments, which enacted § 1395oo, created the Board and for the first time set up a procedure for judicial review of Medicare Part A claims.[17] In so doing, Congress unquestionably intended to expand opportunities for Medicare providers to obtain judicial review, not to restrict them. *See* H.R. Rep. No. 231, 92nd Cong., 1st Sess. 108 (1971); S. Rep. No. 1065, 93d Cong., 2d Sess. (1974). The Federal Circuit found no evidence to the contrary. *See St. Vincent's*, 32 F.3d at 549-50.

Nor did the court below even notice that another portion of the subsection of the Medicare statute at issue here, 42 U.S.C. § 1395ww(d)(7), expressly recognizes that judicial review is available to Medicare providers via § 1395oo "or otherwise." *See* 42 U.S.C. § 1395ww(d)(7). In

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[17] The 1972 amendments created the Board to review matters worth at least $10,000 and allowed judicial review of some of its decisions. *See* Social Security Amendments of 1972, § 243, Pub. L. No. 92-603, 86 Stat. 1329, *reprinted in* 1972 U.S.C.C.A.N. 1548, 1661-63. The 1974 amendments expanded the right to judicial review of Board decisions to all decisions of the Board, as well as to any decision by the Secretary in review of the Board. *See* Act of Oct. 24, 1974, Pub. L. No. 93-484, § 3, 88 Stat. 1459, *reprinted in* 1974 U.S.C.C.A.N. 1674. Prior to the 1972 amendments, the Medicare statute itself did not provide for judicial review of an intermediary's reimbursement decisions. *See Whitecliff*, 536 F.2d at 349.

that subsection, Congress took care to bar all "administrative and judicial review" of several aspects of the new PPS inpatient reimbursement scheme enacted in 1983 (with the statute at issue here). *See id.* The subsection states that "[t]here shall be no administrative or judicial review under section 1395oo of this title or otherwise" of the matters excluded. *See id.*

Having made the "or otherwise" distinction, Congress plainly understood that judicial review is available to providers outside the confines of § 1395oo. The Tucker Act provides review "otherwise", and has done so at least since years in the late 1960's. *See Goldstein*, 201 Ct. Cl. at 889-90.[18]

The Federal Circuit's decisions also failed to take note of this Court's five factor test in *Lindahl v. Office of Personnel Mgmt.*, 470 U.S. 768, 779 (1985), for determining implied repeal. *See, e.g., St. Vincent's*, 32 F.3d at 549-50. Neither the express language of § 1395oo, the structure of the statutory scheme, its objectives, its legislative history nor the nature of the administrative action involved, *see Lindahl*, 470 U.S. at 779, demonstrates with any clarity that Congress wished to repeal Tucker Act jurisdiction over all Medicare claims.

The language of the statute eschews any mention of exclusivity. *See* 42 U.S.C. § 1395oo. The structure of the

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[18] Similarly, under Part B of Medicare, Congress in § 1395ff(b)(3) explicitly restricted review of "any national coverage determination . . . respecting whether or not a particular type or class of items or services is covered. . . . " *See* 42 U.S.C. § 1395ff(b)(3). Congress provided no similar evidence of intent (in the statute or legislative history) to prohibit or restrict review of national outlier payments, and judicial review under § 1395oo, *or otherwise*, must be presumed.

statute indicates that decisions for which no "final determination" is communicated to hospitals *cannot* be appealed through § 1395oo. *See id.* The statute's objectives are to expand, not restrict, judicial review, and the somewhat scanty legislative history is in accord, as discussed. *Cf. Catholic Social Servs.*, 509 U.S. at 56 (courts "customarily refuse to treat" silence about the kind of judicial review sought " 'as a denial of authority to [an] aggrieved person to seek appropriate relief in the federal courts' ") (quoting *Stark v. Wickard*, 321 U.S. 288, 309 (1944)).

The nature of the administrative action involved, the final factor, reinforces the need for Tucker Act review here. The agency action at issue affected all providers in the aggregate, but gave no notice of it to any of them individually. The nature of the administrative action denied the Hospitals review under § 1395oo, which "simply does not speak to" the Hospitals' situation. *See Michigan Academy*, 476 U.S. at 675.

The decision of the Court of Appeals here is erroneous. It unjustly denies all judicial review to the Hospitals for a Medicare action which does not fit within the scheme of § 1395oo.

C. The Ruling in *St. Vincent's* is Contrary to the Plain Language of Section 405(h)

Section 405(h) *does not mention* the Tucker Act, 28 U.S.C. § 1491. By its plain language, section 405(h) at most bars judicial review of Medicare cases under 28 U.S.C. §§ 1331 and 1336, but *not* under the Tucker Act. *See* 42 U.S.C. § 405(h). The blanket statement in *St. Vincent's* that section 405(h) "unequivocally" precludes Federal Claims jurisdiction over Medicare disputes, *see* 32 F.3d at 550, contradicts the plain language of the statute and is obviously in error.

Section 405(h)'s first sentence merely establishes the finality of "a decision of the [Secretary] after a hearing." No hearing occurred here, and the first sentence is inapplicable.

Section 405(h)'s second sentence, "No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided," must be read in the context of the first sentence's definition of the term "decision," i.e., those determinations made by "the [Secretary] after a hearing." *Michigan Academy*, 476 U.S. at 679 & n.8. Again, no hearing occurred in this case.

Section 405's third sentence cannot apply here either. Even in a case under 28 U.S.C. § 1331, to which section 405(h)'s third sentence specifically refers, the Supreme Court refused to read it as the clear and convincing evidence needed to bar judicial review of executive action. *See id.*, 476 U.S. at 679-81. Moreover, the third sentence, as noted, does not bar Tucker Act review.[19]

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[19] *St. Vincent's* transposed the language of the second and third sentences of § 405(h), improperly creating a statutory preclusion of jurisdiction where none exists. The *St. Vincent's* panel paraphrased § 405(h): "Section 405(h) of title 42 of the United States Code, read in conjunction with 42 U.S.C. § 1395ii, unequivocally provides that "no action" arising under the Medicare Act shall be brought in any forum or before any tribunal that is not specifically provided for in the Medicare Act. The Medicare Act does not provide for jurisdiction in the Court of Federal Claims; thus, the Court of Federal Claims is precluded from reviewing reimbursement disputes arising under the Act. . . . Accordingly, under the plain terms of 42 U.S.C. §§ 405(h) and 1395ii, the Court of Federal Claims lacked jurisdiction to review St. Vincent's Medicare reimbursement claim." *St. Vincent's*, 32 F.3d at 550-51. By paraphrasing " 'no action' arising under the Medicare Act shall be brought" from

Finally, *St. Vincent's* is inconsistent both internally and with precedent in the Federal Circuit. Precedent in that circuit has held that Tucker Act jurisdiction exists over provider claims under $10,000, which § 1395oo omits from review, *Appalachian Regional Hosp. v. United States*, 576 F.2d 858, 863 (Ct. Cl. 1978), and over claims for which no review is available elsewhere. *Appalachian Regional Healthcare*, 999 F.2d at 1577. *St. Vincent's* approved that line of cases, which includes *Whitecliff*, 536 F.2d at 351, and *Goldstein*, 201 Ct. Cl. at 889, stating that Tucker Act review exists over Medicare claims for which "Congress has not specified procedures for review," *see* 32 F.3d at 550 (citing *Spokane Valley Gen. Hosp., Inc. v. United States*, 688 F.2d 771, 774-75 (Ct. Cl. 1982)). See also *Spokane Valley*, 688 F.2d at 776. Yet remarkably, two paragraphs later, the court made the contradictory holding that section 405(h) precludes review of *all* Medicare reimbursement claims in the Court of Federal Claims. *See id.* at 550-51.

St. Vincent's holding on section 405(h) would also improperly eliminate jurisdiction over Medicare provider claims of less than $10,000. Section 405(h) does not differentiate between claims on the basis of amount, and *St. Vincent's* sweeping interpretation of § 405(h) would eliminate Tucker Act jurisdiction over claims of less than $10,000, contrary to *Appalachian*, 576 F.2d at 863.

St. Vincent's was wrong in its analysis of the effect of § 405(h) on Tucker Act jurisdiction. Congress has not provided a review procedure to accomodate claims based

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the third sentence of § 405(h) and moving it into conjunction with the phrase "in any forum or before any tribunal," borrowed in part from the second sentence of § 405(h), the *St. Vincent's* panel created a fourth sentence which does not exist in the statute and cannot be relied upon. *See* 42 U.S.C. § 405(h).

on aggregate national outlier payments, and Tucker Act jurisdiction should be available.

CONCLUSION

For these reasons, the Hospitals request that the Court grant a writ of certiorari to the Federal Circuit.

Respectfully submitted,

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October 7, 1996

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

95-5048, -5054, -5097, -5098, -5099, -5108

ALLEMNORE COMMUNITY HOSPITAL, INC.,
d/b/a HUMANA HOSPITAL-TACOMA
and 83 named Plaintiffs,

ALICE PHYSICIANS & SURGEONS HOSPITAL, INC.
and 27 named Plaintiffs,

AIKEN COMMUNITY HOSPITAL, INC. d/b/a AIKEN
REGIONAL MEDICAL CENTER and 54 named Plaintiffs,
Plaintiffs-Appellants,

and

ACCORD MEDICAL MANAGEMENT, LIMITED, d/b/a
NIX MEDICAL CENTER and 47 named Plaintiffs,
Plaintiffs-Appellants,

and

ALLEGHENY GENERAL HOSPITAL and
87 named Plaintiffs,
Plaintiffs-Appellants,

and

MOUNT SINAI MEDICAL CENTER OF
GREATER MIAMI, INC.,
Plaintiff-Appellant,

v.

THE UNITED STATES,
Defendant-Appellee.

JUDGMENT

(Filed Jul. 9, 1996)

On Appeal from the United States Court of Federal Claims in Case Nos. 92-600C, 92-603C, 93-705C, and 93-12C entered February 3, 1995 and April 26, 1995, and in 94-458C entered April 7, 1995.

This CAUSE having been heard and considered, it is

ORDERED AND ADJUDGED:

Per Curiam: (MAYER, LOURIE, and SCHALL, *Circuit Judges*):

AFFIRMED. ***See*** Fed. Cir. R. 36.

ENTERED BY ORDER OF THE COURT

/s/ Francis X. Gindhart, Clerk
FRANCIS X. GINDHART

DATED: JULY 9, 1996

IN THE UNITED STATES CLAIMS COURT

No. 94-458 C

Filed: April 3, 1995

AIKEN COMMUNITY HOSPITAL, INC. d/b/a AIKEN REGIONAL MEDICAL CENTER, *et. al.*

Plaintiffs,

v.

THE UNITED STATES,

Defendant.

ORDER

GRANTING DEFENDANT'S MOTION TO DISMISS

and

DIRECTING ENTRY OF JUDGMENT

The Government has moved for dismissal of this Medicare reimbursement suit for lack of jurisdiction based on the Federal Circuit's opinion in *St. Vincent's Medical Center v. United States*, 32 F.3d 548 (Fed. Cir. 1994). Plaintiffs oppose the motion, claiming that the decision in *St. Vincent's* (a panel decision) stands at odds with established jurisprudence in this judicial circuit declaring that, with respect to pre-1973 Medicare reimbursement claims and claims under $10,000, Tucker Act jurisdiction remains an available avenue for relief.

Although plaintiffs offer a persuasive argument in support of their position, this court simply cannot turn its back to the clear and unequivocal holding against Tucker Act jurisdiction announced in *St. Vincent's*: "Because the Medicare Act contains its own comprehensive administrative and judicial review scheme, there is no Tucker Act jurisdiction over Medicare reimbursement claims." 32 F.3d at 549-50. Whether right or wrong, a pronouncement against jurisdiction as clear as that expressed in the quoted language may not be by-passed by this court in favor of earlier appellate rulings on the same subject. Nor, for that matter, would it be appropriate for this court to express reservations about the correctness of the ruling in St. Vincent's, assuming such reservations could, in fact, be thought to have some validity. That task is properly confined to the appeals process.

The Government's motion to dismiss for lack of jurisdiction must be granted. Accordingly, the Clerk shall entered [sic] judgment dismissing the complaint. No costs.

/s/ John P. Wiese
John P. Wiese
Judge

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

Nos. 92-600C, 92-602C, 92-603C, 93-12C, 93-96C

(Filed Jan. 31, 1995)

ALLEMNORE COMMUNITY HOSPITAL *et al.*, *Plaintiff*, v. THE UNITED STATES, *Defendant*.	Tucker Act jurisdiction; Social Security Act (Medicare)

Thomas Nelson, Nashville, TN, *John R. Hellow*, Los Angeles, CA, *Edgar Morrison, Jr.*, San Antonio, TX, *Keith R. Anderson*, Washington, D.C., for plaintiff with whom was *James A. Barker*, Washington, D.C., of counsel.

Ross D. Cooper, Brian Simkin, and Mark A. Melnick, Washington, D.C., with whom were *Jeanne E. Davidson*, Assistant Director, *David M. Cohen*, Director, Commercial Litigation Branch, Civil Division, and *Frank W. Hunger*, Assistant Attorney General, United States Department of Justice, for defendant.

OPINION

SMITH, Chief Judge

This case raises a somewhat unique question that this court must decline to decide. That question is whether a Federal Circuit panel decision, *St. Vincent's Medical Center v. United States*, 32 F.2d 548 (Fed.Cir. 1994), which deals

with cases related to this one, and which plaintiffs admit is dispositive, should be followed by this court. In *St. Vincent's*, the Federal Circuit panel found no jurisdiction in a factual situation indistinguishable from the instant case.

Plaintiffs argue that *St. Vincent's* should not be followed because it is inconsistent with prior binding Court of Claims, Federal Circuit, and United States Supreme Court precedent. *See e.g., Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986); *Whitecliff v. U.S.*, 210 Ct. Cl. 53, 536 F.2d 347 (1976), *cert. denied, United States v. Whitecliff, Inc.*, 430 U.S. 969 (1977); *Goldstein v. U.S.*, 201 Ct. Cl. 888, *cert. denied, Goldstein v. United States*, 414 U.S. 974, 38 L. Ed. 2d 217, 94 S. Ct. 287 (1973), *reh'g denied, Goldstein v. United States*, 414 U.S. 1087, 38 L.Ed.2d 493, 94 S. Ct. 609 (1973); *Appalachian Regional Healthcare v. United States*, 999 F.2d 1573 (Fed. Cir. 1993); *West Seattle General Hospital, Inc. v. United States*, 230 Ct. Cl. 132, 674 F.2d 899 (1982); *Spokane Valley General Hospital v. United States*, 231 Ct. Cl. 550, 688 F.2d 771 (1982). This court feels that it would be highly adventurous and lacking in appropriate respect for orderly proceedings in our judicial system, for this court to advise the Federal Circuit on whether one of its panels erred. Such is not the role of federal trial courts where it is admitted that the circuit panel's decision is on point. This is particularly true where the decision is of very recent origin. While the Court of Appeals and the litigants expect our court to interpret the law and the precedent, and apply it to individual cases, the trial court has little function in reviewing clear panel decisions, whether or not the trial

court or the litigants think they are consistent with precedent which binds the Federal Circuit or its panels. The trial court does have a rare obligation to point out seemingly anomalous results of apparent circuit precedent in specific cases before it. This, however, is not the present situation.

For the reasons stated here this court must grant the government's motion to dismiss the various plaintiffs' cases pending under this caption so that they may seek review in the appropriate forum for their challenge, the Federal Circuit. In dismissing this case, this court draws no conclusion concerning plaintiffs' exhaustion of statutory remedies under 42 U.S.C. § 1395*oo*.

IT IS SO ORDERED.

/s/ Loren A. Smith
LOREN A. SMITH
CHIEF JUDGE

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

Nos. 92-600C, 92-602C, 92-603C, 93-12C & 93-96C

ALLEMNORE COMMUNITY HOSPITAL,

v. **JUDGMENT**

THE UNITED STATES **(Filed Jan. 31, 1995)**

Pursuant to the court's opinion of January 31, 1995, granting defendant's motion to dismiss,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that the complaint is dismissed.

David A. Lampen
Clerk of Court

By: /s/ [Illegible]
Deputy Clerk

January 31, 1995

NOTE: As to appeal, 60 days from this date, see RCFC 72, re number of copies and listing of *all plaintiffs*. Filing fee is $105.00.

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

ALLEMNORE COMMUNITY HOSPITAL *et al.*,	
Plaintiff,	Nos. 92-600C; 92-602C; 92-603C; 93-12C; 93-96C
v.	
THE UNITED STATES,	(Filed Apr. 17, 1995)
Defendant.	

ORDER

Plaintiff's Motion to Amend the Judgment is GRANTED to the extent of the following amendment to this court's decision in *Allemnore Community Hospital v. United States,* Case Nos. 92-600C; 92-602C; 92-603C; 93-12C; 93-96C. After the final sentence of the original decision, the court will add the following language:

In dismissing this case the court reads *St. Vincent's* as making it irrelevant to jurisdiction in this case whether or not the plaintiffs had a possible remedy before the PRRB. As the Federal Circuit noted in *St. Vincent's,*

> [e]ven if, as [plaintiff] argues, its PRRB appeal will prove unsuccessful, [plaintiff] still has an obligation to satisfy the prerequisities [sic] for judicial review under the Medicare Act. Even if initial application to the PRRB by plaintiffs . . . seems formalistic and futile, as plaintiffs argue, it is a statutory prerequisite to judicial

review which must be followed. (Citations omitted.) *St. Vincent's*, 32 F.3d at 552.

A TRUE COPY:
APR 18 1995
TEST:
DAVID A. LAMPEN
Clerk, U.S. Court of
Federal Claims

By /s/ [Illegible]
Deputy Clerk

/s/ Loren A. Smith
LOREN A. SMITH
CHIEF JUDGE

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

* *

ALICE PHYSICIANS AND SURGEONS HOSPITAL,

Plaintiff,

v.

THE UNITED STATES,

Defendant.

* *

No. 93-705C

Filed: APR 17 1995

ORDER

After consideration of plaintiff's response to this court's show cause order, this case is hereby dismissed in light of the opinion, dated January 31, 1995, in *Allemnore Community Hospital v. United States,* Case Nos. 92-600C; 92-602C; 92-603C; 93-12C; 93-96C, as amended by the court's order dated April 17, 1995.

/s/ Loren A. Smith
LOREN A. SMITH
CHIEF JUDGE

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

No. 93-705 C

ALICE PHYSICIANS AND SURGEONS HOSPITAL,

v.

THE UNITED STATES

JUDGMENT

FILED APR 25 1995

Pursuant to the court's order of April 17, 1995,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that the complaint is dismissed.

David A. Lampen
Clerk of Court

April 25, 1995

By: /s/ Illegible
Deputy Clerk

NOTE: As to appeal, 60 days from this date, see RCFC 72, re number of copies and listing of *all plaintiffs*. Filing fee is $105.00.

ST. VINCENT'S MEDICAL CENTER,
Plaintiff-Appellant,

v.

The UNITED STATES, Defendant-Appellee.

94-5017.

United States Court of Appeals,
Federal Circuit.

Aug. 8, 1994.

(32 F.3d 548 (Fed. Cir. 1994))

Robert E. Mazer, Ober, Kaler, Grimes & Shriver, Baltimore, MD, argued, for plaintiff-appellant. With him on the brief were Leonard C. Homer and Leslie Demaree Goldsmith, of counsel.

Carol Wallack, Atty., Commercial Litigation Branch, Dept. of Justice, Washington, DC, argued, for defendant-appellee. With her on the brief were Frank W. Hunger, Asst. Atty. Gen., David M. Cohen, Director and Jeanne E. Davidson, Asst. Director. Also on the brief was Charles Bailey, Atty., U.S. Dept. of Health and Human Services, Office of the Gen. Counsel, of counsel.

Before MICHEL, CLEVENGER and RADER, Circuit Judges.

MICHEL, Circuit Judge.

St. Vincent's Medical Center (St. Vincent's) appeals the United States Court of Federal Claims' dismissal of St. Vincent's Medicare reimbursement claim for lack of jurisdiction. *St. Vincent's Med. Ctr. v. United States*, 29 Fed.Cl. 165, 173 (1993). We affirm the trial court's decision

because of the requirements of the Medicare statute and the doctrine of exhaustion of administrative remedies.

BACKGROUND

This case involves Medicare reimbursement for certain electricity costs incurred by St. Vincent's related to services it provided to Medicare beneficiaries from 1977 through 1986. As a result of a defective electrical metering system, St. Vincent's belatedly became liable for additional electricity costs in the amount of $2,592,685. Because St. Vincent's was unaware of the unmetered electric costs at the time it submitted its annual cost reports and because of limitations on reopening previously settled cost reports, St. Vincent's received no reimbursement pursuant to 42 U.S.C. § 1395.

St. Vincent's filed a request for retroactive repayment by the government, but the government's intermediary reviewing agency denied the request. St. Vincent's then filed three appeals, in 1988, 1990 and 1991 with the Provider Reimbursement Review Board (PRRB or Board) pursuant to 42 U.S.C. § 1395*oo* (a), challenging the intermediary's denial. Section 1395*oo* (a) states that a provider who is dissatisfied with the intermediary's "final determination . . . as to the amount of total program reimbursement due . . . for the period covered by such report" may request a hearing before the PRRB within 180 days after "notice of the intermediary's final determination." According to the government, the PRRB lacked authority to address St. Vincent's claims for reimbursement for electricity costs for years 1977-1984 because more than 180 days had elapsed from the notices

of final cost determination before St. Vincent's even knew of the additional electric costs. Accordingly, the government asserts that St. Vincent's is unable to establish either PRRB or federal court jurisdiction over its claim.

In November 1992, subsequent to filing the three administrative appeals, but before the PRRB had ruled, St. Vincent's also filed suit in the Court of Federal Claims. The government then moved to dismiss for lack of jurisdiction, and the Court of Federal Claims granted the government's motion. The trial court noted that St. Vincent's had claimed the same relief in the Court of Federal Claims that it sought in its administrative appeals, still pending before the PRRB. The trial court further stated that amendments to the Medicare statute provided for judicial review of Medicare payment determinations in federal district court, and that those amendments impliedly repealed the Tucker Act's grant of jurisdiction to the Court of Federal Claims by revoking the government's waiver of sovereign immunity. St. Vincent's now appeals the Court of Federal Claims' order granting the government's motion to dismiss.

ANALYSIS

I.

Contrary to St. Vincent's assertions, the Medicare Act provides comprehensive administrative and district court review procedures. According to 42 U.S.C. § 1395*oo* (a), a provider seeking judicial review of a denial of reimbursement must first bring its claim before the PRRB. The PRRB will either conduct a hearing concerning the reimbursement dispute or, if the PRRB determines that it lacks

authority to rule upon the challenge, it will certify the case for expedited judicial review, which makes available immediate judicial review in the district courts in lieu of an administrative hearing. 42 U.S.C. § 1395*oo* (f)(1); 42 C.F.R. § 1842. The statute provides:

> Providers shall . . . have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines . . . that it is without authority to decide the question. . . . *Such action shall be brought in the district court of the United States for the judicial district in which the provider is located . . . or in the District Court for the District of Columbia.*

Id. (emphasis added).

With respect to matters that are adjudicated on their merits by the PRRB, the statute provides for district court review of the PRRB's final decision. 42 U.S.C. § 1395*oo* (f)(1).

Because the Medicare Act contains its own comprehensive administrative and judi[550]cial review scheme, there is no Tucker Act jurisdiction over Medicare reimbursement claims. Courts have consistently found preemption of Tucker Act jurisdiction where Congress has enacted a precisely drawn, comprehensive and detailed scheme of review in another forum, as in the present case. *See, e.g., United States v. Fausto,* 484 U.S. 439, 454-55, 108 S.Ct. 668, 677-78, 98 L.Ed.2d 830 (1988); *Harris v. United States,* 841 F.2d 1097, 1100-01 (Fed.Cir.1988); *Fiorentino v. United States,* 607 F.2d 963, 969-70, 221 Ct.Cl. 545 (1979), *cert. denied,* 444 U.S. 1083, 100 S.Ct. 1039, 62 L.Ed.2d 768

(1980). In fact, we recently held in *Appalachian Regional Healthcare, Inc. v. United States*, 999 F.2d 1573, 1577 (Fed.Cir.1993) (citation omitted),[1] that "when the Medicare statute specifically provides for review, providers and courts must follow the specified procedures."

Similarly, in *Whitecliff, Inc. v. United States*, 536 F.2d 347, 351, 210 Ct.Cl. 53 (1976), *cert. denied*, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977), the Court of Claims held

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[1] St. Vincent's attempts to distinguish *Appalachian* from the present case. It states that this court's holding in *Appalachian* was based upon the court's finding that Appalachian Regional Healthcare, Inc. could have but failed to raise its claim in accordance with the review procedures set forth in the Medicare Act. St. Vincent's then argues that it was in a different position because it purportedly had no opportunity to obtain judicial review except pursuant to the Tucker Act. This argument lacks merit because our holding in *Appalachian* did not recognize any such distinction.

Under the Medicare Act, St. Vincent's had an avenue to pursue its reimbursement claims. In fact, St. Vincent's currently has several appeals pending before the PRRB that specifically address the same issue presented here (*i.e.*, whether the hospital should receive reasonable cost Medicare reimbursement for the disputed electrical costs). Given the pending agency appeals addressing the identical reimbursement dispute presented to the Court of Federal Claims, the trial court properly declined to find Tucker Act jurisdiction to resolve this dispute. As the trial judge properly concluded, it is possible that PRRB will grant the provider the relief it seeks. *St. Vincent's Med. Ctr. v. United States*, 29 Fed.Cl. 165, 171 (1993). Moreover, even if the PRRB denies the hospital's request for reimbursement for these electrical costs, or finds that it does not have authority to resolve the issue and certifies the hospital's claim for expedited judicial review, St. Vincent's could appeal its decision to the appropriate United States district court pursuant to 42 U.S.C. § 1395*oo* (f)(1).

that for claims arising after June 30, 1973, it lacked jurisdiction pursuant to the Tucker Act. The court explained that "[w]here the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable. . . . " *Id.* Only where Congress has not specified procedures for review of Medicare reimbursement claims can those claims be entertained under the Tucker Act. *See, e.g., Spokane Valley Gen. Hosp., Inc. v. United States*, 688 F.2d 771, 774-75, 231 Ct.Cl. 550 (1982). As the government properly notes in its brief, the relevant issue is whether there is a comprehensive review scheme that preempts Tucker Act jurisdiction, not, as St. Vincent's suggests, whether the hospital is entitled to the specific remedy it seeks.

Here, because Congress provided a specific and comprehensive scheme for administrative and judicial review of Medicare reimbursement claims, Tucker Act jurisdiction is preempted, and, accordingly, the Court of Federal Claims correctly dismissed this case for lack of jurisdiction.

II.

Even if *Fausto, Harris, Fiorentino, Appalachian* and *Whitecliff* do not support preemption of Tucker Act jurisdiction, the Medicare Act specifically precludes review of reimbursement claims by, inter alia, the Court of Federal Claims. Section 405(h) of title 42 of the United States Code, read in conjunction with 42 U.S.C. § 1395ii, unequivocally provides that "no action" arising under the

Medicare Act shall be brought in any forum or before any tribunal that is not specifically provided for in the Medicare Act. The Medicare Act does not provide for jurisdiction in the Court of Federal Claims; thus, the Court of Federal Claims is precluded from reviewing reimbursement disputes arising under the Act. Although 42 U.S.C. § 405(h) stems from the Social Security Act, the provisions of this section have been incorporated by [551] reference into the Medicare Act by 42 U.S.C. § 1395ii, which provides in relevant part: "The provisions of . . . [42 U.S.C. § 405(h)] . . . shall also apply with respect to [the Medicare Act] to the same extent as they are applicable with respect to [Title II of the Social Security Act]." Accordingly, under the plain terms of 42 U.S.C. §§ 405(h) and 1395ii, the Court of Federal Claims lacked jurisdiction to review St. Vincent's Medicare reimbursement claim.

St. Vincent's responds that the Court of Federal Claims erroneously dismissed this case for lack of jurisdiction because the Tucker Act provides the Court of Federal Claims with jurisdiction where, as here, no other judicial forum is actually available, citing *Mount Sinai Medical Center of Greater Miami, Inc. v. United States*, 13 Cl.Ct. 561, 565 (1987). As noted above, St. Vincent's contends that it could not and cannot invoke the jurisdiction of the PRRB and the related judicial review process to obtain its requested reimbursement because by the time it became aware of the additional costs associated with the unmetered electricity, the 180 day time period it had under 42 U.S.C. § 1395*oo* (a)(3) to invoke the PRRB's jurisdiction for those cost years had expired. Moreover, since a PRRB decision is required before an action may be brought in federal district court, 42 U.S.C. § 1395*oo* (f)(1),

St. Vincent's argues that district court jurisdiction under the Medicare statute was also precluded.

As noted above, however, St. Vincent's has several appeals pending before the PRRB. Even if, as St. Vincent's speculates, the PRRB decides that it lacks jurisdiction and cannot order the cost reimbursement that St. Vincent's seeks because the regulation precludes reopening cost reports for the earlier years, St. Vincent's can appeal that jurisdictional ruling to the district court. It is not, however, within the jurisdiction of the Court of Federal Claims under the Tucker Act to decide the amount of reimbursement and/or whether prior years' cost reports could and should be reopened.

St. Vincent's also relies on the facts of *Mount Sinai* to support its contention that the trial court erred in dismissing this case for lack of jurisdiction. In *Mount Sinai,* a Medicare provider found itself with late assessments from the Florida Patient Compensation Fund (FPCF). The FPCF was a self-insuring trust fund established by the Florida legislature to which all Florida health care providers were required to contribute. Due to unsound actuarial predictions, the fund experienced deficits which required additional assessments against its participants. The Medicare provider asserted reimbursement claims for these late assessments. The Claims Court found that there was no statutory scheme which could provide judicial review in the district court to Mount Sinai because by the time Mount Sinai was billed for the assessments, it was too late to include the costs in the appropriate years' cost reports or to establish PRRB jurisdiction. Given that a PRRB hearing is a prerequisite for review in the district court, the trial judge in *Mount Sinai* concluded that the

Medicare provider lacked any statutory avenue for judicial review. Accordingly, the trial court denied the government's motion to dismiss, finding jurisdiction under the Tucker Act.

The government argues, and we agree, that the holding in *Mount Sinai* is flawed. In essence, the judge in *Mount Sinai* asserted that the court had jurisdiction because the PRRB allegedly refused to exercise its jurisdiction to consider reimbursement for the late FPCF assessments upon the grounds that (1) there was not a timely appeal to the PRRB because the provider was not aware of the assessments before the expiration of the time to seek PRRB review; and (2) for certain years, the late assessments were not included in the hospital's annual cost reports and the intermediary objected to the reopening of the cost reports. The Claims Court reached these conclusions even though it recognized that the PRRB's jurisdictional determination could be appealed to the district court. The court simply stated that, "even if plaintiff appeals the FPCF issue to the district court, the district court is bound to conclude that the PRRB denial of jurisdiction was correct." *Mount Sinai,* 13 Cl.Ct. at 565-66.

[552] *Mount Sinai* simply presumed that a district court would agree with the PRRB's decision despite the fact that the hospital could have argued and the district court may have concluded otherwise. Nevertheless, *Mount Sinai* premised its decision on this unwarranted assumption that the hospital could not obtain judicial review of the administrative decision in federal district court. Based on the foregoing, the Claims Court judge erroneously determined that Tucker Act jurisdiction existed.

Applying the holding of *Mount Sinai* to the present case, St. Vincent's contention that the Medicare Act does not provide any avenue for judicial review lacks merit for the same reason that *Mount Sinai's* "lack of review" argument is without merit. Contrary to St. Vincent's suggestion, the Medicare Act affords St. Vincent's the opportunity to present its reimbursement claims before the PRRB. The PRRB can then decide whether and how to reimburse St. Vincent's. If the PRRB rules adversely to St. Vincent's, the hospital may then appeal to the appropriate district court either on the merits or on jurisdiction.

Moreover, to the extent *Mount Sinai* cannot be distinguished, we hold that it is erroneous and we overrule it.

III.

In addition to the preemption and section 405(h) reasons discussed above, the trial court also properly dismissed this case for lack of jurisdiction because taking Tucker Act jurisdiction over this dispute would violate the well-established doctrine that regulated parties must exhaust all available administrative remedies before they receive judicial review where, as here, Congress has explicitly so required. *See, e.g., Heckler v. Ringer,* 466 U.S. 602, 627, 104 S.Ct. 2013, 2028, 80 L.Ed.2d 622 (1984) (Congress in the Medicare Act required that administrative remedies be exhausted before judicial review of the Secretary's decision may take place). Like the plaintiff in *Ringer,* St. Vincent's no doubt prefers an "immediate appeal . . . rather than the often lengthy administrative review process" required in the PRRB. *Ringer,* 466 U.S. at 619, 104 S.Ct. at 2024. St. Vincent's, however, must

"adhere to the administrative procedure which Congress has established for adjudicating [its] Medicare claims." *Id.* Because St. Vincent's still has appeals pending with the PRRB, neither the district court nor the Court of Federal Claims presently possesses jurisdiction to consider St. Vincent's Medicare reimbursement claims.

Even if, as St. Vincent's argues, its PRRB appeal will prove unsuccessful, St. Vincent's still has an obligation to satisfy the prerequisites for judicial review under the Medicare Act. *Id.* at 605, 104 S.Ct. at 2016-17; *see also Aristocrat South, Inc. v. Mathews*, 420 F.Supp. 23, 26 (D.D.C.1976) ("Even if initial application to the PRRB by plaintiffs of its [sic] claims seems formalistic and futile, as plaintiffs argue, it is a statutory prerequisite to judicial review which must be followed.").

CONCLUSION

For the foregoing reasons, each of which is independently sufficient, we affirm the Court of Federal Claims' dismissal for lack of jurisdiction.

AFFIRMED.

28 U.S.C. § 1491(a)(1) provides:

> The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. For the purpose of this paragraph, an express or implied contract with the Army and Air Force Exchange Service, Navy Exchanges, Marine Corps Exchanges, Coast Guard Exchanges, or Exchange Councils of the National Aeronautics and Space Administration shall be considered an express or implied contract with the United States.

42 U.S.C. § 405(h) provides:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary] or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code, to recover on any claim arising under this title.

42 U.S.C. § 1395ii provides:

> The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k) and (l) of section 405, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II . . .

42 U.S.C. § 1395oo(a) provides:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –
>
> (1) such provider –
>
> (A) (i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395(h) as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. § 1395oo(f)(1) provides:

A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at

the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review

by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this subsection must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

Supreme Court, U.S.
FILED
DEC 16 1996

No. 96-578

In the Supreme Court of the United States

OCTOBER TERM, 1996

ALLEMNORE COMMUNITY HOSPITAL, INC., ET AL.,
PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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16 pp

QUESTION PRESENTED

Whether the Tucker Act, 28 U.S.C. 1491, provides for review of claims by providers of Medicare services when 42 U.S.C. 1395*oo* of the Medicare Act provides for administrative and judicial review of such claims.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

No. 96-578

ALLEMNORE COMMUNITY HOSPITAL, INC., ET AL.,
PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The order of the court of appeals (Pet. App. 1-2) is unpublished, but the decision is noted at 92 F.3d 1206 (Table). The opinion of the United States Court of Federal Claims (Pet. App. 5-7, 9-10) is reported at 32 Fed. Cl. 608. The orders of the United States Court of Federal Claims (Pet. App. 11-12) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on July 9, 1996. The petition for a writ of certiorari was filed on October 7, 1996. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Title XVIII of the Social Security Act establishes a federally funded health insurance program for the elderly and disabled known as Medicare. See 42 U.S.C. 1395 *et seq.* (the Medicare Act). The Secretary of Health and Human Services (the Secretary) has delegated administrative responsibility for the program to the administrator of the Health Care Financing Administration (HCFA). The Social Security Amendments of 1983 amended 42 U.S.C. 1395ww and replaced the "reasonable cost" system of reimbursing provider hospitals with a Prospective Payment System, under which payment rates generally are established without regard to a hospital's actual costs. See *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993).

Section 1395ww also provides for additional payments in "outlier" cases in which a patient's hospital stay is unusually lengthy or costly when compared to most discharges classified within the same discharge related group (DRG). 42 U.S.C. 1395ww(d)(5)(A). The Secretary is required to establish payment criteria applicable to all Medicare hospitals for outlier cases prior to each federal fiscal year. *Ibid.* The total amount of outlier payments made under Section 1395ww(d)(5)(A) for discharges in a fiscal year "may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. 1395ww(d)(5)(A)(iv). For each fiscal year since 1984, the Secretary has established prospective outlier payment criteria so

that nationwide outlier payments were expected to equal between five and six percent of total PPS inpatient services payments. See, *e.g.*, 48 Fed. Reg. 39,776-39,777 (1983); 49 Fed. Reg. 264-266 (1984).[1]

In January 1984, the Secretary stated that outlier criteria and payments for a fiscal year would not be adjusted retroactively based on actual annual Medicare payment data for that fiscal year:

> Using the data we had available, we set the outlier criteria so that an estimated six percent of total payments would be made for outliers. Nevertheless, there is no necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria. While we expect that under these criteria outlier payments will approximate six percent of total payments, we will pay for any outlier that meets the criteria, even if aggregate outlier payments result in more than six percent of total payments. Under such circumstances, we will continue to make these payments for the remainder of the Federal fiscal year without adjusting the DRG rates to compensate for the additional payments. Similarly, if we overestimate the amount of outlier payments, we will not adjust the DRG rates

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[1] To make outlier payments budget-neutral, Congress directed the Secretary to reduce PPS rates to reflect the percentage of expected outlays for outlier payments. 42 U.S.C. 1395ww(d)(2)(E) and (3)(B).

> to compensate hospitals for funds that were not actually paid for outlier cases.

49 Fed. Reg. 265 (1984). The Secretary reiterated that position in succeeding years.[2]

2. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), which is made applicable to the Medicare Act by 42 U.S.C. 1395ii, provides:

> The findings and decision of the [Secretary[3]] after a hearing shall be binding upon all individuals who were parties to such hearing. *No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided.* No action against the United States, the [Secetary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter."

42 U.S.C. 405(h) (emphasis added).

The Medicare Act allows provider hospitals to challenge their payments under the Medicare program. Each fiscal year, hospitals submit to a fiscal intermediary a cost report containing the hospital's request for reimbursement. 42 U.S.C. 1395h; 42 C.F.R. 413.20. The fiscal intermediary audits the cost report and issues a Notice of Program Reimbursement

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[2] See 50 Fed. Reg. 35,708-35,710 (1985); 51 Fed. Reg. 31,523-31,525 (1986); 52 Fed. Reg. 33,047-33,049 (1987); 53 Fed. Reg. 38,504-38,510 (1988); 54 Fed. Reg. 36,498-36,500 (1989); 55 Fed. Reg. 36,075-36,077 (1990); 56 Fed. Reg. 43,227 (1991).

[3] Section 1395ii provides that the reference to the Commissioner of Social Security in Section 405(h) "shall be considered a reference to the Secretary * * * of Health and Human Services." 42 U.S.C. 1395ii.

(NPR) reflecting the total program reimbursement due the provider for items and services covered by the Medicare Act. 42 C.F.R. 405.1803, 405.1807, 413.60; see *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 401 (1988).

Under Section 1395*oo*, a provider that is "dissatisfied with a final determination of * * * its fiscal intermediary * * * as to the amount of total program reimbursement due the provider," or that is "dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection * * * (d) of section 1395ww," may request a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*(a)(1)(A)(i) and (ii).[4] The provider must request such a hearing within 180 days of the fiscal intermediary's final determination, and the amount in controversy must equal or exceed $10,000. 42 U.S.C. 1395*oo*(a)(2) and (3).[5] The Board may "affirm, modify, or reverse a final determination of the fiscal intermediary." 42 U.S.C. 1395*oo*(d). The Secretary further may either affirm, reverse, or modify the Board's decision. 42 U.S.C. 1395*oo*(f)(1). Following a final decision of the PRRB (or any reversal, affirmance, or modification by the Secretary), a provider may seek judicial review in the United States District Court in the judicial district where the provider is located or in the District of

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[4] Under the Act, certain determinations (not relevant here) are not reviewable. 42 U.S.C. 1395*oo*(g).

[5] For "good cause," the PRRB may waive the 180-day limitation for up to a three-year period. 42 C.F.R. 405.1841(b). The Secretary's regulations also allow for a hearing before the fiscal intermediary for amounts in controversy of at least $1,000 but less than $10,000. 42 C.F.R. 405.1809(a) and (b)(2).

Columbia. *Ibid.* Section 1395*oo* also provides for expedited judicial review in district court whenever the Board determines that it lacks authority over any "question of law or regulations relevant to the matters in controversy." *Ibid.*; see *Bethesda Hosp. Ass'n*, 485 U.S. at 401.

3. Petitioners are hospital providers which filed suit in the United States Court of Federal Claims to seek additional outlier payments for fiscal years 1985 and 1986 because the payments in those years allegedly "were less than the outlier payments due them under 42 U.S.C. § 1395ww(d)(5)(A)(iv)." Pet. 5. Petitioners contend that the court had jurisdiction over their claims under the Tucker Act, 28 U.S.C. 1491(a)(1).[6] Petitioners did not seek administrative or judicial review under Section 1395*oo* within 180 days after receipt of their NPR for the contested cost years, because, they allege, they were not aware until 1992 of the total amount of outlier payments nationwide in 1985 and 1986. Pet. 4-6.

The government moved to dismiss petitioners' respective complaints for lack of jurisdiction, claiming that the review procedures mandated by Section 1395*oo* preclude jurisdiction under the Tucker Act. During the pendency of the motion to dismiss, the Federal Circuit decided *St. Vincent's Medical Center* v. *United States*, 32 F.3d 548 (1994) (Pet. App. 13-23),

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[6] In relevant part, 28 U.S.C. 1491(a)(1) provides:

> The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States.

which held that "[b]ecause the Medicare Act contains its own comprehensive administrative and judicial review scheme, there is no Tucker Act jurisdiction over Medicare reimbursement claims." Pet. App. 16. Citing *St Vincent's*, the Court of Federal Claims granted the government's motions to dismiss petitioners' suits. *Id.* at 5-12. The cases were consolidated on appeal, and the Federal Circuit affirmed without opinion. *Id.* at 1-2.

ARGUMENT

The court of appeals' decision is correct and does not conflict with any decision of this Court or any other court of appeals. Further review is not warranted.

1. Section 205(h) of the Social Security Act, incorporated into the Medicare Act by 42 U.S.C. 1395ii, provides that "[n]o * * * decision of the [Secretary] shall be reviewed" by any "tribunal" except as provided by the Medicare Act. 42 U.S.C. 405(h). Because petitioners did not avail themselves of the administrative and judicial review procedures under Section 1395*oo*, the Federal Circuit correctly held that petitioners' claims must be dismissed.

Contrary to petitioners' suggestion (Pet. 8-12), construing Section 205(h) to limit judicial review here does not conflict with *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). This Court held in *Michigan Academy* that 42 U.S.C. 405(h) and 1395ff(b)(1)(C) do not foreclose review in district court of the Secretary's Medicare Part B regulations establishing the method of determining benefits. 476 U.S. at 675, 680. The Court was guided by "the strong presumption that Congress intends judicial review of administrative action" and the ab-

sence of any explicit provision in Part B (as it then existed) for judicial review. *Id.* at 670. In the present case, however, petitioners seek under the Tucker Act review of agency action precisely contemplated by Section 1395*oo*, *i.e.*, the amounts of their reimbursements, including payments for outlier cases. Unlike in *Michigan Academy*, application of Section 205(h) to bar Tucker Act jurisdiction in the present case would not deny providers a means to obtain judicial review of their claims.

Prior to 1972, the Medicare Act did not permit hospital providers to challenge their Medicare cost determinations. S. Rep. No. 1230, 92d Cong., 2d Sess. 51 (1972). The Act was amended in 1972 and 1974 to establish the PRRB and provide a comprehensive scheme for review of payment disputes involving amounts of $10,000 or more. Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1420, 42 U.S.C. 1395*oo*; Act of Oct. 26, 1974, Pub. L. No. 93-484, § 3(a), 88 Stat. 1459, 42 U.S.C. 1395*oo*(f). Thus, the administrative and judicial review procedures of Section 1395*oo* are exclusive as to claims covered by Section 1395*oo*.

This Court has held that when Congress enacts a comprehensive administrative and judicial review scheme for challenging agency action, the Tucker Act does not provide an alternative basis for review. See *United States* v. *Fausto*, 484 U.S. 439, 448-449 (1988) (review procedures in the Civil Service Reform Act preclude judicial review under the Tucker Act); *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982) (Medicare Act's review provisions under Part B of the Medicare program preclude judicial review under the

Tucker Act).[7] Similarly, because Section 1395*oo* sets forth a precisely drawn and comprehensive scheme of judicial review of payments to providers under the Medicare program, the Tucker Act does not provide the Court of Federal Claims with jurisdiction to hear petitioners' claims.[8]

Petitioners do not dispute that their claims are covered by Section 1395*oo*'s review procedures. Pet.

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[7] This rule is consistent with the principle that a remedy furnished by a precisely drawn, detailed statute preempts a more general, otherwise applicable remedy. See, *e.g.*, *Brown* v. *General Services Admin.*, 425 U.S. 820 (1976) (Title VII of Civil Rights Act of 1964 preempts preexisting employment discrimination remedies); *Preiser* v. *Rodriguez*, 411 U.S. 475 (1973) (state prisoners may not seek redress under Civil Rights Act because of comprehensive remedial scheme of habeas corpus); *United States* v. *Demko*, 385 U.S. 149 (1966) (prison workers' compensation system preempts Federal Tort Claims Act); *Stonite Products Co.* v. *Melvin Lloyd Co.*, 315 U.S. 561 (1942) (specific venue statute for patent infringement cases is exclusive law governing venue in such cases).

[8] Petitioners mistakenly rely (Pet. 12-16) on cases disfavoring implied repeal of Tucker Act jurisdiction. See, *e.g.*, *Preseault* v. *Interstate Commerce Comm'n*, 494 U.S. 1 (1990); *Ruckelshaus* v. *Monsanto*, 467 U.S. 986 (1984). Those cases arose under the Just Compensation Clause and did not involve the present situation in which Congress specifically has provided for review of the purported claims in another forum. Similarly, petitioners' contention (Pet. 24) that there is no "'[c]lear and convincing evidence' of congressional intent to bar all judicial review" is erroneous in light of Section 1395*oo*. See also *Block* v. *Community Nutrition Inst.*, 467 U.S. 340, 350-351 (1984) ("This Court has * * * never applied the 'clear and convincing evidence' standard in the strict evidentiary sense," but "has found the standard met, and the presumption favoring judicial review overcome, whenever the congressional intent to preclude judicial review is 'fairly discernible in the statutory scheme.'" (citation omitted)).

4-6. Indeed, hundreds of Medicare providers have invoked Section 1395*oo* to challenge the level of their outlier reimbursement as not meeting the five percent projection required by Section 1395ww(d)(5)(A)(iv). See, *e.g.*, *Alvarado Community Hosp.* v. *Shalala*, No. CV 94-0972 (and consolidated cases) (C.D. Cal. May 3, 1996), appeal pending, No. 96-55967 (9th Cir., filed June 19, 1996). Petitioners' contention that they could not timely pursue review under Section 1395*oo* "through no fault of [their] own" (Pet. i), even if true,[9] does not create jurisdiction under the Tucker Act. Because Congress directed that providers dissatisfied with the program payments, including outlier payments computed under Section 1395ww(d)(5)(A), must first seek review before the PRRB, petitioners first must present their claims, including any arguments that would overcome the time limitations of Section 1395*oo*, to the PRRB. If the PRRB determines that petitioners are not entitled to relief for any reason, petitioners must seek judicial review of the PRRB's decision in district court. 42 U.S.C. 1395*oo*(f)(1).[10]

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[9] Petitioners argue (Pet. 4-5, 14) that, until 1992, they did not receive the Secretary's "final determination" of total aggregate outlier payments. However, the Secretary is not required to publish actual Medicare payment data on a nationwide basis, and the Secretary first set forth the prospective payment methodology for outlier payments in 1984. 49 Fed. Reg. 264-266 (1984). Thus, the absence of national data on total outlier payments did not prevent petitioners from making their own claims under Section 1395*oo*(a) within 180 days after receipt of their NPRs for any given cost year.

[10] The fact that petitioners may seek judicial consideration of their claims under Section 1395*oo* also belies petitioners' contention (Pet. 23-24) that to preclude Tucker Act jurisdiction over those same claims would raise constitutional questions.

2. Judicial review is also precluded because petitioners have not exhausted their administrative remedies before the PRRB. *Heckler* v. *Ringer*, 466 U.S. 602 (1984) (exhaustion of administrative remedies is mandatory in the Medicare program). Tucker Act jurisdiction would not relieve petitioners of their obligation to pursue administrative review before presenting their claims to the courts. See *Ruckelshaus* v. *Monsanto Co.*, 467 U.S. 986, 1018 (1984) (requiring exhaustion of administrative remedies before seeking relief under Tucker Act). Because petitioners failed to seek any review under Section 1395*oo*, the courts below properly dismissed their claims.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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DECEMBER 1996

No. 96-578

Supreme Court, U.S.
FILED
DEC 31 1996
CLERK

In The

Supreme Court of the United States

October Term, 1996

ALLEMNORE COMMUNITY HOSPITAL, INC., *et al.*,

Petitioners,

v.

THE UNITED STATES,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Federal Circuit

REPLY TO BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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ARGUMENT

Petitioners reply to new matter raised in the Brief of United States in Opposition to Petitioners Petition for Writ of Certiorari. The Government has made two statements that leave an incorrect impression with the Court.

1) First, the Government asserts that "hundreds of Medicare providers have invoked Section 1395oo to challenge the level of their outlier reimbursement . . . ", citing *Alvarado Community Hosp. v. Shalala,* No. CV 94-0972 (and consolidated cases) (C.D. Cal 1996), appeal pending, No. 96-55967 (9th Cir., filed June 19, 1996), (Opp. 10.), and concludes that Petitioners similarly could have utilized section 1395oo rather than the Tucker Act. All the hospitals in *Alvarado,* however, previously had filed appeals on other Medicare reimbursement issues, and added the outlier payments issue to their pending appeals after the 180-day appeal window had elapsed,[1] as provided by 42 C.F.R. § 405.1841(a)(1). Contrary to the implication in the Government's brief, only one hospital in the nation has ever been identified as having noticed an appeal of the outlier issues within the 180-day appeal window for either of the two cost reporting years involved in this case (1985 and 1986).

The *Alvarado* hospitals fortuitously had appeals pending to which they could add an outlier payment challenge. The 305 hospital Petitioners had no such appeals pending, however, and were unable to present

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[1] Counsel for the *Alvarado* hospitals, John Hellow of Hooper, Lundy & Bookman, Inc., is counsel for many of the hospitals in these cases.

their claims in a timely fashion to the PRRB. That is precisely the dilemma described to the Court by Hospitals as a basis for the Court to exercise its jurisdiction to review these cases. (Pet. 20, n.13, 21-22.) The government's assertions about the significance of *Alvarado* prove precisely the opposite point, *viz.*, that Hospitals have been deprived of equal protection of the laws, and that they were unable – through no fault of their own – to utilize the statutory remedies of section 1395oo.

2) The government also asserts that "petitioners have not exhausted their administrative remedies before the PRRB." (Opp. 11.) That Hospitals have, however, exhausted their *available* administrative remedies by submitting requests for reopening to their fiscal intermediaries, the Secretary's agents, and so alleged in their complaints. Pet. 5-6, 19, 24.[2]

The PRRB was not available to the Hospitals, the large majority of which could not have made use of the three-year "good cause" extension for PRRB appeals under 42 C.F.R. § 1841(b) even if that regulation is valid. *See* Pet. 20, n.13; Opp. 5, n.5. If the three-year extension was not available to a hospital, any waivable requirement imposed by the Secretary should be deemed to have been waived or met. *Cf. Heckler v. Ringer,* 466 U.S. 602, 617 (1984) (noting a two-part exhaustion requirement under separate portion of Social Security Act, comprised of non-

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[2] The hospitals had no available administrative remedy similar to hospitals with claims less than $10,000 – which even the government and the Federal Circuit acknowledge may invoke the Tucker Act. *See Appalachian Reg. Healthcare, Inc. v. United States,* 999 F.2d 1573, 1577 (Fed. Cir. 1993).

waivable presentment requirement and waivable requirement that administrative remedies prescribed by Secretary be followed). In addition, 42 U.S.C. § 405(h)'s second sentence should be deemed to have been met even if the governments' interpretation of it is correct (which it is not).

No finding of fact has been made as to which Hospitals had even the opportunity to utilize the "good cause" regulation. *See* App. 3-12. A remand to the trial court would be necessary to make such a determination. It would be improper to make any such factual finding, in the guise of a ruling on exhaustion, on appeal in the Federal Circuit or this Court.

CONCLUSION

Petitioners request that the Court grant the writ of certiorari to the Federal Circuit.

Respectfully submitted,

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December 30, 1996